District of Columbia

OFFICIAL CODE

2001 Edition

Volume 16

Title 31

Insurance and Securities
(Chapters 10 to End)

2012
Pocket Part

Replacing 2011 pocket part in back of 2009 main volume

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PREFACE

These annual cumulative pocket parts update the District of Columbia Official Code, 2001 Edition, with permanent, temporary, and emergency legislation and judicial constructions contained in annotations. These pocket parts contain the Laws, general and permanent in their nature, relating to or in force in the District of Columbia (except such laws as are of application in the General and Permanent Laws of the United States) as of May 10, 2012.

Notes of decisions of District and Federal courts include cases published through May 1, 2012.

Current legislation between pamphlets or pocket parts can be obtained on WestlawNext or Westlaw DC–LEGIS Database.

The unannotated District of Columbia Official Code can be accessed on the District of Columbia Council website at http://www.dccouncil.us.

Later laws and annotations will be cumulated in the subsequent pamphlets and annual Pocket Parts.

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DISTRICT OF COLUMBIA OFFICIAL CODE 2001 Edition

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§ 31–1131.05. Examination prior to licensure.

(a) An individual applying for a resident insurance producer license shall pass a written examination unless the individual is:

(1) Applying for a limited lines insurance producer license or a license in the surplus lines line of authority; or

(2) Exempt from examination under § 31–1131.05b or § 31–1131.09.

(a–1) The examination required by subsection (a) of this section shall test the knowledge of the individual concerning the lines of authority for which application is made, the duties and responsibilities of an insurance producer, and the insurance laws and regulations of the District.

(b) The Commissioner may make arrangements, including contracting with an outside testing service, for administering examinations and collecting a nonrefundable fee for the examination.

(c) Each individual applying for an examination shall remit a nonrefundable fee for the examination as prescribed by the Commissioner.

(d) An individual who fails to appear for the examination as scheduled or fails to pass the examination may reapply for an examination. The individual shall remit all required fees and forms before being rescheduled for another examination.

(Mar. 27, 2003, D.C. Law 14–264, § 5, 50 DCR 260; May 13, 2008, D.C. Law 17–155, § 2(c), 55 DCR 3683; Sept. 24, 2010, D.C. Law 18–223, § 2166(a), 57 DCR 6242.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 18–223 substituted "§ 31–1131.05b or § 31–1131.09" for "§ 31–1131.09".

Emergency Act Amendments

For temporary (90 day) amendment of section, see § 2166(a) of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–101.

§ 31–1131.05a. Pre–licensing education.

(a) The Commissioner may require, by rule, that an individual, other than an applicant for a title insurance producer license, complete a pre-licensing course of study before:

(1) Taking the examination required by § 31–1131.05; or

(2) Applying for an insurance producer license.

(b) An insurer that sells, solicits, or negotiates a limited line of insurance in the District shall provide to each individual whose duties will include selling, soliciting, or negotiating the insurer's limited line of insurance in the District a program of instruction that is approved by the Commissioner. The insurer shall provide the program of instruction to the individual prior to the individual's application for licensure as a limited lines insurance producer.

(Mar. 27, 2003, D.C. Law 14–264, § 5a, as added May 13, 2008, D.C. Law 17–155, § 2(d), 55 DCR 3683; Sept. 24, 2010, D.C. Law 18–223, § 2166(b), 57 DCR 6242.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 18–223, in subsec. (a), substituted "individual, other than an applicant for a title insurance producer license, complete" for "individual complete".

Emergency Act Amendments

For temporary (90 day) amendment of section, see § 2166(b) of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–101.

§ 31–1131.05b. Pre–licensing education for title insurers.

(a) The Commissioner shall require, by rule, that an individual, not exempt under subsections (b), (c), or (d) of this section, complete a pre-licensing course of study before:

(1) Taking the examination required by § 31–1131.05; or

(2) Applying for an insurance producer license.

(b) An attorney who holds a license to practice law in any state or the District of Columbia shall be exempt from pre-licensing course of study requirements and examination requirements.

(c) An title agent insurance applicant who provides certification from a title insurance insurer that the agent has had signing authority on policies or title insurance commitments for the past 3 years relating to properties located within the District of Columbia shall be exempt from the pre-licensing course of study requirements and the examination requirements; provided, that the certification is submitted to the Commissioner within one year after September 24, 2010.

(d) A full-time employee of a title insurer shall be exempt from the pre-licensing course of study requirement.

(e) The District of Columbia Land Title Association, or other organization designated by the Commissioner by rule, shall provide to each individual whose duties will include selling, soliciting, or negotiating a title insurer's limited line of title insurance in the District a program of instruction that is approved by the Commissioner. The insurer shall provide the program of instruction to the individual prior to the individual's application for licensure as a limited lines insurance producer.

(Mar. 27, 2003, D.C. Law 4–264, § 5b, as added Sept. 24, 2010, D.C. Law 18–223, § 2166(3), 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition of section, see § 2166(3) of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–101.

§ 31–1131.06. Application for resident insurance producer license.

(a) An individual applying for a resident insurance producer license shall make application to the Commissioner on the Uniform Individual Application and declare under penalty of refusal, suspension, or revocation of the license that the statements made in the application are true, correct, and complete to the best of the individual's knowledge and belief. Before approving the application, the Commissioner shall find that the individual:

(1) Is at least 18 years of age;

(2) Has not committed any act that is a ground for denial, suspension, or revocation set forth in § 31–1131.12; provided, that if an applicant for a title insurance producer license has been convicted of any such act and 10 years have elapsed since the individual's conviction, and a title insurer submits written verification that the person has had authority from the title insurer to issue title insurance policies or commitments related to real or personal property within the District of Columbia for a period of not less than 3 years prior

to the application for license, such act or conviction may be considered not to apply by the Commissioner;

(3) If required by the Commissioner, has completed a pre–licensing course of study for the lines of authority for which the person has applied;

(4) Has paid the fees prescribed by the Commissioner; and

(5) Unless exempt under § 31–1131.09, has successfully passed the examinations for the lines of authority for which the person has applied.

(b) A business entity applying for a resident business entity producer license shall make application to the Commissioner on the Uniform Business Entity Application. Before approving the application, the Commissioner shall find that the business entity has:

(1) Paid the fees prescribed by the Commissioner; and

(2) Designated a licensed individual producer responsible for the business entity's compliance with the insurance laws, rules, and regulations of the District.

(c) The Commissioner may require any documents reasonably necessary or appropriate to verify the information contained in an application.

(d) Repealed.

(Mar. 27, 2003, D.C. Law 14–264, § 6, 50 DCR 260; May 13, 2008, D.C. Law 17–155, § 2(e), 55 DCR 3683; Mar. 25, 2009, D.C. Law 17–353, § 234, 56 DCR 1117; Sept. 24, 2010, D.C. Law 18–223, § 2166(c), 57 DCR 6242.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 18–223, in subsec. (a)(2), substituted "set forth in § 31–1131.12; provided, that if an applicant for a title insurance producer license has been convicted of any such act and 10 years have elapsed since the individual's conviction, and a title insurer submits written verification that the person has had authority from the title insurer to issue title insurance policies or commitments related to real or personal property within the District of Columbia for a period of not less than 3 years prior to the application for license, such act or conviction may be considered not to apply by the Commissioner" for "set forth in § 31–1131.12".

Emergency Act Amendments

For temporary (90 day) amendment of section, see § 2166(c) of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–101.

§ 31–1131.07b. Continuing education.

(a) A title insurance producer shall fulfill the following continuing education requirements:

(1) Eight hours per year, of which not more than 4 hours may be completed by computer or video-based education; or

(2) If the title insurance producer is an attorney, 4 hours per year in courses related to real estate and continuing education courses approved by the Commissioner by rule.

(b) The Commissioner may establish continuing education requirements for resident insurance producers.

(Mar. 27, 2003, D.C. Law 14–264, § 7b, as added May 13, 2008, D.C. Law 17–155, § 2(h), 55 DCR 3683; Sept. 24, 2010, D.C. Law 18–223, § 2166(d), 57 DCR 6242.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 18–223 rewrote the section, which had read as follows:

"The Commissioner may establish continuing education requirements for resident insurance producers."

Emergency Act Amendments

For temporary (90 day) amendment of section, see § 2166(d) of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–101.

§ 31–1131.08. Nonresident licensing.

(a) A person may request a nonresident license if the person is licensed as a resident insurance producer in another state.

(a–1) A person requesting a nonresident insurance producer license shall make his or her request on a form, or through such means, prescribed by the Commissioner.

(a–2) Unless denied licensure under § 31–1131.12 or granted a resident insurance producer license by meeting the requirements of §§ 31–1131.05 and 31–1131.06, a nonresident person shall receive a nonresident insurance producer license if:

(1) The person is currently licensed as a resident and in good standing in his or her home state;

(2) The person has submitted the proper request for a nonresident insurance producer license and has paid the fees as prescribed by the Commissioner; and

(3) The person has submitted or transmitted to the Commissioner a completed NAIC Uniform Application or the application for licensure that the person submitted to his or her home state.

(b) The Commissioner may verify the insurance producer's licensing status through the producer database maintained by the NAIC, its affiliates, or subsidiaries.

(c) Repealed.

(d) Notwithstanding any other provision of this chapter, a person licensed as a surplus lines producer in his or her home state shall receive a nonresident surplus lines producer license under subsection (a) of this section. Except as provided in subsection (a) of this section, this section shall not amend or supersede any provision of §§ 31–2502.39 and 31–2502.40.

(e) Notwithstanding any other provision of this chapter, a person licensed as a limited line insurance producer in his or her home state shall receive a nonresident limited lines insurance producer license under subsection (a) of this section granting the same scope of authority as granted under the license issued by the producer's home state. For the purposes of this subsection, the term "limited line insurance" means any authority granted by the home state which restricts the authority of the license to less than the total authority prescribed in the associated major lines under § 31–1131.07(a)(1) through (6).

(f) An applicant may qualify for a license under this chapter as a nonresident only if the applicant holds an equivalent license in the applicant's home state. A license issued to a nonresident of the District shall grant the same rights and privileges as a resident licensee.

(g) A nonresident title insurance producer shall have a registered agent in the District of Columbia at the time of application for a title insurance producer license and shall maintain a registered agent in the District of Columbia as a condition of licensing under this section.

(Mar. 27, 2003, D.C. Law 14–264, § 8, 50 DCR 260; May 13, 2008, D.C. Law 17–155, § 2(i), 55 DCR 3683; Sept. 24, 2010, D.C. Law 18–223, § 2166(e), 57 DCR 6242.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 18–223 added subsec. (g).

Emergency Act Amendments

For temporary (90 day) amendment of section, see § 2166(e) of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–101.

Chapter 12

Insurance Regulatory Trust Fund.

Section

31–1201. Definitions.

§ 31–1201. Definitions.

For the purposes of this chapter, the term:

(1) "Assessable year" means the calendar year in which the direct gross receipts are received or derived from insurance business in the District of Columbia.

(1A) "Commissioner" means the Commissioner of the Department of Insurance, Securities, and Banking.

(1A–i) "Continuing Care Retirement Community Regulatory and Supervision Trust Account" or "Account" means the account established within the Insurance Regulatory Trust Fund for the purpose of administering Chapter 1A of Title 44, and for reasonable expenses incurred in promoting the continuing care retirement community industry in the District.

(1B) "Department of Insurance, Securities, and Banking" means the District of Columbia's regulatory body which is responsible for administering the insurance laws and health maintenance organization laws of the District of Columbia.

(2) "Direct gross receipts" means all policy and membership fees and net premium receipts or consideration received in a calendar year on all insurance risks and annuity contracts originating in or from the District of Columbia. Direct gross receipts shall not include any policy or membership fees, net premium receipts, or consideration received from or paid by the District of Columbia's Department of Health Care Finance.

(3) Repealed.

(4) "Insurer" means any person, firm, association, or corporation duly licensed in the District of Columbia pursuant to the applicable provisions of District insurance law as an insurer. In addition, Group Hospitalization and Medical Service Incorporated, shall be defined as an insurer.

(5) "Net premium receipts or consideration received" means gross premiums or consideration received less the sum of premiums received for reinsurance assumed and premiums or consideration returned on policies or contracts canceled or not taken.

(6) Repealed.

(Oct. 21, 1993, D.C. Law 10–40, § 2, 40 DCR 6009; Apr. 9, 1997, D.C. Law 11–235, § 24(a), 44 DCR 818; May 21, 1997, D.C. Law 11–268, § 10(y), 44 DCR 1730; Mar. 24, 1998, D.C. Law 12–81, § 36(a), 45 DCR 745; June 11, 2004, D.C. Law 15–166, § 4(h)(1), 51 DCR 2817; Apr. 5, 2005, D.C. Law 15–270, § 201(a), 52 DCR 799; Sept. 24, 2010, D.C. Law 18–223, § 5024, 57 DCR 6242.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 18–223, in par. (2), added the last sentence.

Temporary Amendments of Section

Section 4 of D.C. Law 18–205, in par. (2), inserted "Direct gross receipts shall not include any policy or membership fees, net premium receipts, or consideration received from or paid by the Department of Health Care Finance.".

Section 7(b) of D.C. Law 18–205 provides that the act shall expire after 225 days of its having taken effect.

Emergency Act Amendments

For temporary (90 day) amendment of section, see § 4 of Medicaid Resource Maximization Emergency Amendment Act of 2010 (D.C. Act 18–390, May 7, 2010, 57 DCR 4339).

For temporary (90 day) amendment of section, see § 5024 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–101.

Chapter 13A

Investments of Insurers.

Subchapter I. General Provisions.

Section

31–1371.02. Definitions.

SUBCHAPTER I. GENERAL PROVISIONS.

§ 31–1371.02. Definitions.

For the purposes of this chapter, the term:

(1) "Acceptable collateral" means:

(A) As to securities lending transactions, and for the purpose of calculating the counterparty exposure amount, cash, cash equivalents, letters of credit, direct obligations of, or securities that are fully guaranteed as to principal and interest by, the government of the United States, any agency of the United States, the Federal National Mortgage Association, or the Federal Home Loan Mortgage Corporation;

(B) As to foreign lending securities transactions, investments set forth in subparagraph (A) of this paragraph and sovereign debt rated 1 by the SVO;

(C) As to repurchase transactions, cash, cash equivalents and direct obligations of, or securities that are fully guaranteed as to principal and interest by, the government of the United States, an agency of the United States, the Federal National Mortgage Association, or the Federal Home Loan Mortgage Corporation; and

(D) As to reverse repurchase transactions, cash and cash equivalents.

(2) "Acceptable private mortgage insurance" means insurance written by a private insurer protecting a mortgage lender against loss occasioned by a mortgage loan default and issued by a licensed mortgage insurance company, with an SVO 1 designation or a rating issued by a nationally recognized statistical rating organization equivalent to an SVO 1 designation, that covers losses to an 80% loan–to–value ratio.

(3) "Accident and health insurance" means protection which provides payment of benefits for covered sickness or accidental injury, excluding credit insurance, disability insurance, accidental death and dismemberment insurance, and long–term care insurance.

(4) "Accident and health insurer" means a licensed life or health insurer or health service corporation whose insurance premiums and required statutory reserves for accident and health insurance constitute at least 95% of total premium considerations or total statutory required reserves, respectively.

(5) "Admitted assets" means assets having economic value which can be used to fulfill policy obligations and permitted, as allowed in the National Association of Insurance Commissioners Accounting Practices and Procedures Manual, to be reported as admitted assets on the statutory financial statement of the insurer most recently required to be filed with the Commissioner, but excluding assets of separate accounts, the investments of which are not subject to the provisions of this chapter.

(6) "Affiliate" means, as to any person, another person that, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with the person.

(7) "Asset–backed security" means a security or other instrument, excluding a mutual fund, evidencing an interest in, providing the right to receive payments from, or payable from distributions on, an asset, a pool of assets, or specifically divisible cash flows which are legally transferred to a trust or another special purpose bankruptcy–remote business entity, under the following conditions:

(A) The trust or other business entity is established solely for the purpose of acquiring specific types of assets or right to cash flows, issuing securities and other instruments representing an interest in or right to receive cash flows from those assets or rights, and engaging in activities required to service the assets or rights and any credit enhancement or support features held by the trust or other business entity; and

(B) The assets of the trust or other business entity consist solely of interest–bearing obligations or other contractual obligations representing the right to receive payment from the cash flows from the assets or rights; provided, that the existence of credit enhancements, such as letters of credit or guarantees, or support features, such as swap agreements, shall not disqualify the security or other instrument as an asset–backed security.

(8) "Business entity" includes a sole proprietorship, corporation, limited liability company, association, partnership, joint stock company, joint venture, mutual fund, trust, joint

tenancy or other similar form of business organization, whether organized for profit or not for profit.

(9) "Cap" means an agreement obligating the seller to make payments to the buyer, with each payment based on the amount by which a reference price or level or the performance or value of one or more underlying interests exceeds a predetermined number, sometimes called the strike rate or strike price.

(10) "Capital and surplus" means the sum of the capital and surplus of the insurer required to be shown on the statutory financial statement of the insurer most recently required to be filed with the Commissioner.

(11) "Cash equivalents" means short–term, highly rated, and highly liquid investments or securities readily convertible to known amounts of cash without penalty. Cash equivalents shall include government money market mutual funds and class one money market mutual funds. For the purposes of this definition:

(A) "Short–term" means investments with a remaining term to maturity of 90 days or less.

(B) "Highly rated" means an investment rated P–1 by Moody's Investors Services, Inc., A–1 by the Standard and Poor's division of The McGraw Hill Companies, Inc., or its equivalent rating by a nationally recognized statistical rating organization recognized by the SVO.

(12) "Class one bond mutual fund" means a bond mutual fund that at all times qualifies for investment using the bond class one reserve factor under the *Purposes and Procedures of the Securities Valuation Office* or any successor publication.

(13) "Class one money market mutual fund" means a money market mutual fund that at all times qualifies for investment using the bond class one reserve factor under the *Purposes and Procedures of the Securities Valuation Office* or any successor publication.

(14) "Code" means the laws relating to insurance which are codified in this title of the D.C. Official Code.

(15) "Collar" means an agreement to receive payments as the buyer of an option, cap, or floor and to make payments as the seller of a different option, cap, or floor.

(16) "Commercial mortgage loan" means a loan secured by a mortgage other than a residential mortgage loan.

(17) "Construction loan" means a loan with a term of less than 3 years made for financing the cost of construction of a building or other improvement to real estate and secured by the real estate to be improved.

(18) "Control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract (other than a commercial contract for goods or non–management services), or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, 10% or more of the voting securities of another person. This presumption may be rebutted by a showing that control does not exist in fact. The Commissioner may determine, after furnishing all interested persons notice and an opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(19)(A) "Counterparty exposure amount" means the net amount of credit risk attributable to a derivative instrument entered into with a business entity other than through a qualified exchange, qualified foreign exchange, or cleared through a qualified clearinghouse ("over–the–counter derivative instrument").

(B)(i) The net amount of credit risk equals:

(I) The market value of the over–the–counter derivative instrument if the liquidation of the derivative instrument would result in a final cash payment to the insurer; or

(II) Zero if the liquidation of the derivative instrument would not result in a final cash payment to the insurer.

(ii) If over–the–counter derivative instruments are entered into under a written master agreement which provides for netting of payments owed by the respective

parties, and the domiciliary jurisdiction of the counterparty is either within the United States or, if not within the United States, within a foreign jurisdiction listed in the *Purposes and Procedures of the Securities Valuation Office* as eligible for netting, the net amount of credit risk shall be the greater of zero or the net sum of:

(I) The market value of the over–the–counter derivative instruments entered into under the agreement, the liquidation of which would result in a final cash payment to the insurer; and

(II) The market value of the over–the–counter derivative instruments entered into under the agreement, the liquidation of which would result in a final cash payment by the insurer to the business entity.

(iii) For open transactions, market value shall be determined at the end of the most recent quarter of the insurer's fiscal year and shall be reduced by the market value of acceptable collateral held by the insurer or placed in escrow by one or both parties.

(20) "Covered" means that, in an income generation transaction, an insurer owns or can immediately acquire, through the exercise of options, warrants, or conversion rights already owned, the underlying interest to fulfill or secure its obligations under a call option, cap, or floor it has written, or has set aside under a custodial or escrow agreement cash or cash equivalents with a market value equal to the amount required to fulfill its obligations under a put option it has written.

(21) "Credit tenant loan" means a mortgage loan which is made primarily in reliance on the credit standing of a major tenant, structured with an assignment of the rental payments to the lender, and is secured by a first lien on the real estate.

(22)(A) "Derivative instrument" means an agreement, option, instrument, or a series or combination thereof:

(i) To make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests;

(ii) To make a cash settlement in lieu thereof; or

(iii) That has a price, performance, value, or cash flow based primarily upon the actual or expected price, level, performance, value, or cash flow of one or more underlying interests.

(B) Derivative instruments shall include options, warrants used in a hedging transaction and not attached to another financial instrument, caps, floors, collars, swaps, forwards, and futures; any other agreements, options, or instruments substantially similar thereto, or any series or combination thereof; and any agreements, options, or instruments permitted under regulations adopted under § 31–1375.01. Derivative instruments shall not include an investment authorized by §§ 31–1372.03 through 31–1372.09, 31–1372.11, and 31–1373.04 through 31–1373.10.

(23) "Derivative transaction" means a transaction involving the use of one or more derivative instruments.

(24) "Direct" or "directly", when used in connection with an obligation, means that the designated obligor is primarily liable on the instrument representing the obligation.

(25) "Dollar roll transaction" means 2 simultaneous transactions with different settlement dates no more than 96 days apart, where, in the first transaction, an insurer sells to a business entity and, in the second transaction, the insurer is obligated to purchase from the same business entity, substantially similar securities of the following types:

(A) Asset–backed securities issued, assumed, or guaranteed by the Government National Mortgage Association, the Federal National Mortgage Association, or the Federal Home Loan Mortgage Corporation, or their respective successors; and

(B) Other asset–backed securities referred to in section 106 of the Secondary Mortgage Market Enhancement Act of 1984, approved October 3, 1984 (98 Stat.1691; 15 U.S.C. § 77r–1).

(26) "Domestic jurisdiction" means the United States, Canada, the District of Columbia, any state, any province of Canada, or any political subdivision of any of the foregoing.

(27) "Equity interest" means any of the following that are not rated credit instruments:

(A) Common stock;

(B) Preferred stock;

(C) Trust certificate;

(D) Equity investment in an investment company other than a money market mutual fund or a class one bond mutual fund;

(E) Investment in a common trust fund of a bank regulated by a federal or state agency;

(F) An ownership interest in minerals, oil, or gas, the rights to which have been separated from the underlying fee interest in the real estate where the minerals, oil, or gas are located;

(G) Instruments which are mandatorily, or at the option of the issuer, convertible to equity;

(H) Limited partnership interests and those general partnership interests authorized under § 31–1371.05;

(I) Member interests in limited liability companies;

(J) Warrants or other rights to acquire equity interests that are created by the person that owns or would issue the equity to be acquired; or

(K) Instruments that would be rated credit instruments except as excluded by paragraph (71)(B) of this section.

(28) "Equivalent securities" means:

(A) In a securities lending transaction, securities that are identical to the loaned securities in all features, including the amount of the loaned securities, except as to certificate number if held in physical form; provided, that if any different security shall be exchanged for a loaned security by recapitalization, merger, consolidation, or other corporate action, the different security shall be deemed to be the loaned security;

(B) In a repurchase transaction, securities that are identical to the purchased securities in all features, including the amount of the purchased securities, except as to the certificate number if held in physical form; or

(C) In a reverse repurchase transaction, securities that are identical to the sold securities in all features, including the amount of the sold securities, except as to the certificate number if held in physical form.

(29) "Floor" means an agreement obligating the seller to make payments to the buyer in which each payment is based on the amount by which a predetermined number, sometimes called the floor rate or price, exceeds a reference price, level, performance, or value of one or more underlying interests.

(30) "Foreign currency" means a currency other than that of a domestic jurisdiction.

(31)(A) "Foreign investment" means an investment in a foreign jurisdiction, or any investment in a person, real estate, or asset domiciled in a foreign jurisdiction, that is substantially of the same type as those eligible for investment under this chapter, other than under §§ 31–1372.09 and 31–1373.10. An investment shall not be a foreign investment if the issuing person, qualified primary credit source, or qualified guarantor is a domestic jurisdiction or a person domiciled in a domestic jurisdiction, unless:

(i) The issuing person is a shell business entity; and

(ii) The investment is not assumed, accepted, guaranteed, insured, or otherwise backed by a domestic jurisdiction or a person, that is not a shell business entity, domiciled in a domestic jurisdiction.

(B) For the purposes of this definition:

(i) "Shell business entity" means a business entity having no economic substance except as a vehicle for owning interests in assets issued, owned, or previously owned by a person domiciled in a foreign jurisdiction.

(ii) "Qualified guarantor" means a guarantor against which an insurer has a direct claim under contract for full and timely payment for which an enforcement action can be brought in a domestic jurisdiction.

(iii) "Qualified primary credit source" means the credit source to which an insurer looks for payment as to an investment and against which an insurer has a direct claim under contract for full and timely payment for which an enforcement action can be brought in a domestic jurisdiction.

(32) "Foreign jurisdiction" means a jurisdiction other than a domestic jurisdiction.

(33) "Forward" means an agreement (other than a future) to make or take delivery of, or effect a cash settlement based on the actual or expected price, level, performance, or value of, one or more underlying interests.

(34) "Future" means an agreement, traded on a qualified exchange or qualified foreign exchange, to make or take delivery of, or effect a cash settlement based on the actual or expected price, level, performance or value of, one or more underlying interests.

(35) "Government money market mutual fund" means a money market mutual fund that at all times:

(A) Invests only in obligations issued, guaranteed, or insured by the federal government of the United States or collateralized repurchase agreements composed of these obligations; and

(B) Qualified for investment without a reserve under the *Purposes and Procedures of the Securities Valuation Office* or any successor publication.

(36) "Government–sponsored enterprise" means a:

(A) Governmental agency; or

(B) Corporation, limited liability company, association, partnership, joint stock company, joint venture, trust, or other entity or instrumentality organized under the laws of any domestic jurisdiction to accomplish a public policy or other governmental purpose; provided, that this subparagraph shall not apply to any entity or instrumentality which qualifies for exemption under section 501(c)(3) of the Internal Revenue Code of 1986, approved October 26, 1986 (68A Stat. 163; 26 U.S.C. § 501(c)(3)).

(37) "Guaranteed or insured", when used in connection with an obligation acquired under this chapter, means that the guarantor or insurer has agreed to:

(A) Perform or insure the obligation of the obligor or purchase the obligation; or

(B) Be unconditionally obligated until the obligation is repaid to maintain in the obligor a minimum net worth, fixed charge coverage, minimum stockholders' equity, or sufficient liquidity to enable the obligor to pay the obligation in full.

(38) "Hedging transaction" means a derivative transaction which is entered into and maintained to reduce:

(A) The risk of a change in the value, yield, price, cash flow, or quantity of assets or liabilities which the insurer has acquired or incurred or anticipates acquiring or incurring; or

(B) The currency exchange rate risk or the degree of exposure as to assets or liabilities which an insurer has acquired or incurred, or anticipates acquiring or incurring.

(39) "High grade investment" means a rated credit instrument rated 1 or 2 by the SVO.

(40) "Income" means, as to a security, interest, accrual of discount, dividends, or other distributions, such as rights, tax or assessment credits, warrants, and distributions in kind.

(41) "Income generation transaction" means a derivative transaction involving the writing of covered call option, covered put options, covered caps, or covered floors that is intended to generate income or enhance return.

(42) "Initial margin" means the amount of cash, securities, or other consideration initially required to be deposited to establish a futures position.

(43) "Insurance future" means a future relating to an index or pool that is based on insurance-related items.

(44) "Insurance futures option" means an option on an insurance futures contract.

(45) "Investment company" means an investment company as defined in section 3(a)(1) of the Investment Company Act of 1940, approved August 20, 1940 (56 Stat. 867; 15 U.S.C. § 80a–3(a)(1)), and a person described in section 3(c) of the Investment Company Act of 1940, approved August 20, 1940 (56 Stat. 867; 15 U.S.C.§ 80a–3(c)).

(46) "Investment company series" means an investment portfolio of an investment company that is organized as a series company and to which assets of the investment company have been specifically allocated.

(47) "Investment practices" means transactions of the types described in § 31–1372.08, § 31–1372.10, § 31–1373.09, or § 31–1373.11.

(48) "Investment subsidiary" means a subsidiary of an insurer engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the insurer if each subsidiary agrees to limit its investment in any asset so that its

investments will not cause the amount of the total investment of the insurer to exceed any of the investment limitations or avoid any other provisions of this chapter applicable to the insurer. For the purposes of this paragraph, the total investment of the insurer shall include:

(A) Direct investment by the insurer in an asset; and

(B) The insurer's proportionate share of an investment in an asset by an investment subsidiary of the insurer, which share shall be calculated by multiplying the amount of the subsidiary's investment by the percentage of the insurer's ownership interest in the subsidiary.

(49) "Investment strategy" means the techniques and methods used by an insurer to meet its investment objectives, such as active bond portfolio management, passive bond portfolio management, interest rate anticipation, growth investment, and value investing.

(50) "Letter of credit" means a clean, irrevocable, and unconditional letter of credit issued or confirmed by, and payable and presentable at, a financial institution on the list of financial institutions meeting the standards for issuing letters of credit under the *Purposes and Procedures of the Securities Valuation Office*, or any successor publication. To constitute acceptable collateral for the purposes of § 31–1372.08 and § 31–1373.02, a letter of credit shall have an expiration date beyond the term of the subject transaction.

(51) "Limited liability company" means an entity that is an unincorporated association, having perpetual duration, having one or more members that is organized and existing under Chapter 8 of Title 29, or under the laws of the United States or any state thereof that limits the personal liability of each member to the equity investment of the member in the business entity.

(52) "Lower grade investment" means a rated credit instrument rated 4, 5, or 6 by the SVO.

(53) "Market value" means:

(A) As to cash and a letter of credit, the amount thereof; and

(B) As to a security, as of any date, the price of the security on that date obtained from a generally recognized source or the most recent quotation from such a source or, to the extent no generally recognized source exists, the price for the security as determined in good faith by the parties to a transaction, plus accrued but unpaid income thereon to the extent not included in the price as of that date.

(54) "Medium grade investment" means a rated credit instrument rated 3 by the SVO.

(55) "Modified guaranteed contracts" means a modified guaranteed annuity or modified guaranteed life insurance policy or contract.

(56) "Money market mutual fund" means a mutual fund that meets the conditions of 17 C.F.R. § 270.2a–7.

(57) "Mortgage loan" means an obligation secured by a mortgage, deed of trust, trust deed, or other consensual lien on real estate.

(58) "Multilateral development bank" means an international development organization of which the United States is a member.

(59) "Mutual fund" means an investment company or, in the case of an investment company that is organized as a series company, an investment company series, that is registered with the United States Securities and Exchange Commission under the Investment Company Act of 1940, approved August 20, 1940 (56 Stat. 789; 15 U.S.C. § 80a–1 *et seq.*).

(60) "NAIC" means the National Association of Insurance Commissioners.

(61) "Obligation" means a bond, note, debenture, trust certificate, including an equipment certificate, production payment, negotiable bank certificate of deposit, bankers' acceptance, credit tenant loan, loan secured by financing, net leases and other evidence of indebtedness for the payment of money (or participations, certificates, or other evidences of an interest in any of the foregoing), whether constituting a general obligation of the issuer or payable only out of certain revenues or certain funds pledged or otherwise dedicated for payment.

(62)(A) "Option" means an agreement giving the buyer the right to buy or receive, sell or deliver, enter into, extend or terminate or effect a cash settlement based on the actual or expected price, level, performance, or value of one or more underlying interests.

(B) "Call option" means the right of the buyer to buy or receive the option.

(C) "Put option" means the right of the buyer to sell or deliver the option.

(63) "Person" means an individual, a business entity, a multilateral development bank, or a government or quasi–governmental body, such as a political subdivision or a government–sponsored enterprise.

(64) "Potential exposure" means the amount determined in accordance with the NAIC Annual Statement Instructions.

(65) "Preferred stock" means stock of a business entity, which stock has a preference in liquidation over the common stock of the business entity.

(66) "Qualified bank" means:

(A) A national bank, state bank, or trust company that at all times is no less than adequately capitalized as determined by standards adopted by United States banking regulators and that is either regulated by state banking laws or is a member of the Federal Reserve System; or

(B) A bank or trust company incorporated or organized under the laws of a country other than the United States that is regulated as a bank or trust company by that country's government or an agency thereof and that at all times is no less than adequately capitalized as determined by the standards adopted by international banking authorities.

(67) "Qualified business entity" means a business entity that is:

(A) An issuer of obligations or preferred stock that are rated 1 or 2 by the SVO or an issuer of obligations, preferred stock, or derivative instruments that are rated the equivalent of 1 or 2 by the SVO or by a nationally recognized statistical rating organization recognized by the SVO; or

(B) A primary dealer in United States government securities, recognized by the Federal Reserve Bank of New York.

(68) "Qualified clearinghouse" means a clearinghouse for, and subject to the rules of, a qualified exchange or a qualified foreign exchange, which provides clearing services, including acting as a counterparty to each of the parties to a transaction such that the parties no longer have credit risk as to each other.

(69) "Qualified exchange" means:

(A) A securities exchange registered as a national securities exchange or a securities market regulated under the Securities Exchange Act of 1934 approved June 6, 1934 (48 Stat. 881; 15 U.S.C. § 78 *et seq.*);

(B) A board of trade or commodities exchange designated as a contract market by the Commodity Futures Trading Commission;

(C) Private Offerings, Resales and Trading through Automated Linkages (PORTAL);

(D) A designated offshore securities market as defined in 17 C.F.R. § 230. 902(b); or

(E) A qualified foreign exchange.

(70) "Qualified foreign exchange" means a foreign exchange, board of trade, or contract market located outside the United States, its territories, or possessions:

(A) That has received regulatory comparability relief under Rule 30.10, Appendix C, 17 C.F.R. Part 30 ("Rule 30.10");

(B) That is, or its members are, subject to the jurisdiction of a foreign futures authority that has received regulatory comparability relief under Rule 30.10 as to futures transactions in the jurisdiction where the exchange, board of trade, or contract market is located; or

(C) Upon which foreign stock index futures contracts are listed that are the subject of no–action relief issued by the Office of General Counsel of the Commodity Futures Trading Commission; provided, that an exchange, board of trade, or contract market that is a qualified foreign exchange under this subparagraph shall only be a qualified foreign exchange as to foreign stock index futures contracts that are the subject of no–action relief.

(71)(A) "Rated credit instrument" means a contractual right to receive cash or another rated credit instrument from another entity which instrument:

(i) Is rated, or required to be rated, by the SVO;

(ii) In the case of an instrument with a maturity not exceeding 397 days, is issued, guaranteed, or insured by an entity that is rated by, or another obligation of such entity is rated by, the SVO or by a nationally recognized statistical rating organization recognized by the SVO;

(iii) In the case of an instrument with a maturity not exceeding 90 days, is issued by a qualified bank;

(iv) Is a share of a class one bond mutual fund; or

(v) Is a share of a money market mutual fund.

(B) The term "rated credit instrument" shall not mean:

(i) An instrument that is mandatorily, or at the option of the issuer, convertible to an equity interest; or

(ii) A security that has a par value and whose terms provide that the issuer's net obligation to repay all or part of the security's par value is determined by reference to the performance of an equity, a commodity, a foreign currency, or an index of equities, commodities, foreign currencies, or combinations thereof.

(72)(A) "Real estate" means:

(i) Real property;

(ii) Interests in real property, such as leaseholds, minerals, and oil and gas that have not been separated from the underlying fee interest;

(iii) Improvements and fixtures located on or in real property; or

(iv) The seller's equity in a contract providing for a deed of real estate.

(B) As to a mortgage on a leasehold estate, real estate shall include the leasehold estate only if it has an unexpired term, including renewal options exercisable at the option of the lessee, extending beyond the scheduled maturity date of the obligation that is secured by a mortgage on the leasehold estate by a period equal to the greater of 20% of the original term of the obligation or 10 years.

(73) "Replication transaction" means a derivative transaction that is intended to replicate the performance of one or more assets that an insurer may acquire under this chapter. A derivative transaction that is entered into as a hedging transaction shall not be considered a replication transaction.

(74) "Repurchase transaction" means a transaction in which an insurer purchases securities from a business entity that is obligated to repurchase the purchased securities or equivalent securities from the insurer at a specified price, either within a specified period of time or upon demand.

(75) "Required liabilities" means total liabilities required to be reported on the statutory financial statement of the insurer most recently required to be filed with the Commissioner.

(76) "Residential mortgage loan" means a loan primarily secured by a mortgage on real estate improved with a residence for up to 4 families.

(77) "Reverse repurchase transaction" means a transaction in which an insurer sells securities to a business entity and is obligated to repurchase the sold securities or equivalent securities from the business entity at a specified price, either within a specified period of time or upon demand.

(78) "Secured location" means the contiguous real estate owned by one person.

(79) "Securities lending transaction" means a transaction in which securities are loaned by an insurer to a business entity that is obligated to return the loaned securities or equivalent securities to the insurer, either within a specified period of time or upon demand.

(80) "Series company" means an investment company that is organized as a series company, as defined in SEC Rule 18f–2(a), 17 C.F.R. § 270.18f–2.

(81) "Sinking fund stock" means preferred stock that:

(A) Is subject to a mandatory sinking fund or similar arrangement that will provide for the redemption or open market purchase of the entire issue over a period not longer than 40 years from the date of acquisition; and

(B) Provides for mandatory sinking fund installments or open market purchases commencing not more than 10.5 years from the date of issue, with the sinking fund installments providing for the purchase or redemption, on a cumulative basis commenc-

ing 10 years from the date of issue, of at least 2.5% per year of the original number of shares of that issue of preferred stock.

(82) "Special rated credit instrument" means a rated credit instrument that is:

(A) An instrument that is structured so that, if it is held until retired by or on behalf of the issuer, its rate of return, based on its purchase cost and any possible cash flow, may become negative due to reasons other than the credit risk associated with the issuer of the instrument; provided, that a rated credit instrument shall not be a special rated credit instrument under this subsection if it is:

(i) A share in a class one bond mutual fund;

(ii) An instrument, other than an asset–backed security, which:

(I) Has payments of par value fixed as to amount and timing or is callable;

(II) Is payable only at par or greater; and

(III) Has interest or dividend cash flows that are based on either a fixed or variable rate determined by reference to a specified rate or index;

(iii) An instrument, other than an asset–backed security, that has a par value and is purchased at a price no greater than 110% of par value;

(iv) An instrument, including an asset–backed security, whose rate of return would become negative only as a result of a prepayment due to casualty, condemnation or economic obsolescence of collateral, or change of law;

(v) An asset–backed security that relies on collateral that meets the requirements of sub–subparagraph (ii) of this subparagraph, the par value of which collateral:

(I) Is not permitted to be paid sooner than 1/2 of the remaining term to maturity from the date of acquisition;

(II) Is permitted to be paid prior to maturity only at a premium sufficient to provide a yield to maturity for the investment, considering the amount prepaid and reinvestment rates at the time of early repayment, at least equal to the yield to maturity of the initial investment; or

(III) Is permitted to be paid prior to maturity at a premium at least equal to the yield of a treasury issue of comparable remaining life; or

(vi) An asset–backed security that relies on cash flows from assets that are not prepayable at any time at par value, but is not otherwise governed by sub–subparagraph (v) of this subparagraph, if the asset–backed security has par value reflecting principal payments to be received if held until retired by or on behalf of the issuer and is purchased at a price not greater than 105% of such par amount; or

(B)(i) An asset–backed security that:

(I) Relies on cash flows from assets that are prepayable at par value at any time;

(II) Does not make payments of par value that are fixed as to amount and timing; and

(III) Has a negative rate of return at the time of acquisition if a prepayment threshold assumption is used, with the prepayment threshold assumption defined as:

(aa) Twice the prepayment expectation reported by a recognized, publicly available source as being the median of expectations contributed by broker–dealers or other entities, except insurers, engaged in the business of selling or evaluating such securities or assets. The prepayment expectation used in this calculation shall be, at the insurer's election, the prepayment expectation for pass–through securities of the Federal National Mortgage Association, the Federal Home Loan Mortgage Corporation, the Government National Mortgage Association, or for other assets of the same type as the assets that underlie the asset–backed security, in either case which has a gross weighted average coupon comparable to the gross weighted average coupon of the assets that underlie the asset–backed security; or

(bb) Another prepayment threshold assumption specified by the Commissioner by regulation promulgated under § 31–1375.01.

(ii) For the purposes of this subparagraph, if the asset–backed security is purchased in combination with one or more other asset–backed securities that are supported by

identical underlying collateral, the insurer may calculate the rate of return for these specific combined asset–backed securities in combination; provided, that the insurer shall maintain documentation demonstrating that the securities were acquired and are continuing to be held in combination.

(83) "State" means any of the several states, the District of Columbia, the Commonwealth of Puerto Rico, the U. S. Virgin Islands, Guam, American Samoa, and the Commonwealth of Northern Mariana Islands.

(84) "Substantially similar securities" means securities that meet all criteria for substantially similar specified in the NAIC *Accounting Practices and Procedures Manual*, and in an amount that constitutes good delivery form as determined from time to time by the Public Securities Administration.

(85) "SVO" means the Securities Valuation Office of the NAIC, or any successor office established by the NAIC.

(86) "Swap" means an agreement to exchange or to net payments at one or more times based on the actual or expected price, level, performance, or value of one or more underlying interests.

(87) "Variable contracts" means a variable annuity or a variable life insurance policy.

(88) "Underlying interest" means the assets, liabilities, other interests or a combination thereof underlying a derivative instrument, such as any one or more securities, currencies, rates, indices, commodities, or derivative instruments.

(89) "Unrestricted surplus" means the amount by which total admitted assets exceed 125% of the insurer's required liabilities.

(90) "Warrant" means an instrument that gives the holder the right to purchase an underlying financial instrument at a given price and time or at a series of prices and times outlined in the warrant agreement. Warrants may be issued alone or in connection with the sale of other securities or to facilitate divestiture of the securities of another business entity.

(Apr, 11, 2003, D.C. Law 14–297, § 102, 50 DCR 330; July 2, 2011, D.C. Law 18–378, § 3(v), 58 DCR 1720.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 18–378, in par. (51), substituted "Chapter 8 of Title 29" for "Chapter 10 of Title 29".

Legislative History of Laws

For history of Law 18–378, see notes under § 31–754.

Chapter 16A

Public Insurance Adjuster Licensure.

Section

31–1631.04. Licensure.

§ 31–1631.04. Licensure.

(a) The Commissioner shall issue a license to an applicant for a public insurance adjuster's license who:

(1) Has paid the applicable fee established by the Commissioner by rule;

(2) Passes a written examination for which a fee may be charged; and

(3) Has sufficient experience, training, and instruction concerning the adjusting of first party claims for damages or losses under insurance contracts that insure the real or personal property of the insured, as determined by the Commissioner in accordance with regulations issued pursuant to this chapter.

(b) The Commissioner may issue a license to any applicant without an examination if:

(1) The applicant holds a like license in good standing from another state and the public official having supervision of public insurance adjusters in the other state certifies that the applicant has passed a written examination; and

(2) The other state recognizes public insurance adjusters with District public insurance adjuster licenses for the purpose of licensing the applicant without the requirement of an examination.

(c) A license issued pursuant to this section shall continue in force from the date of issuance until April 30th of the next odd-numbered year, unless suspended, revoked, or otherwise terminated prior thereto. Requests for renewal of the license shall be made to the Commissioner and accompanied by the license fee. Unless a request for renewal, accompanied by the appropriate fee, is received by the termination date, the license shall expire.

(Mar. 27, 2003, D.C. Law 14–256, § 4, 50 DCR 238; Sept. 24, 2010, D.C. Law 18–223, § 2172, 57 DCR 6242.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 18–223, in subsec. (a)(1), substituted "established by the Commissioner by rule" for "specified by this chapter".

Emergency Act Amendments

For temporary (90 day) amendment of section, see § 2172 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–101.

Miscellaneous Notes

Short title: Section 2171 of D.C. Law 18–223 provided that subtitle N of title II of the act may be cited as the "Public Insurance Adjuster Licensure Amendment Act of 2010".

Chapter 20

Risk–Based Capital.

Section

31–2003. Company Action Level Event.

§ 31–2003. Company Action Level Event.

(a) For the purposes of this chapter, the term "Company Action Level Event" means any of the following events:

(1) The filing of an RBC Report by an insurer which indicates that:

(A) The insurer's total adjusted capital is greater than or equal to its Regulatory Action Level RBC, but less than its Company Action Level RBC;

(B) If a life or health insurer, the insurer has total adjusted capital which is greater than or equal to its Company Action Level RBC, but less than the product of its Authorized Control Level RBC and 2.5 and has a negative trend; or

(C) If licensed as a property and casualty insurer, the insurer has total adjusted capital which is greater than or equal to its Company Action Level RBC, but less than the product of its Authorized Control Level RBC and 3.0, and triggers the trend test determined in accordance with the trend test calculation included in the Property and Casualty RBC instructions;

(2) The notification by the Commissioner to the insurer of an Adjusted RBC Report that indicates an event in paragraph (1) of this subsection, provided the insurer does not challenge the Adjusted RBC Report under § 31–2007; or

(3) If, pursuant to § 31–2007, an insurer challenges an Adjusted RBC Report that indicates the event in paragraph (1) of this subsection, the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

(b) In the event of a Company Action Level Event, the insurer shall prepare and submit to the Commissioner an RBC Plan which shall:

(1) Identify the conditions which contribute to the Company Action Level Event;

(2) Contain proposals of corrective actions which the insurer intends to take and would be expected to result in the elimination of the Company Action Level Event;

(3) Provide projections of the insurer's financial results in the current year and at least the 4 succeeding years, both in the absence of proposed corrective actions and giving effect

to the proposed corrective actions, including projections of statutory operating income, net income, capital, or surplus. The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense, and benefit component;

(4) Identify the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

(5) Identify the quality of, and problems associated with, the insurer's business, including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance, if any, in each case.

(c) The RBC Plan shall be submitted to the Commissioner within 45 days of the Company Action Level Event; or if the insurer challenges an Adjusted RBC Report pursuant to § 31–2007, within 45 days after notification to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

(d) Within 60 days after the submission by an insurer of an RBC Plan to the Commissioner, the Commissioner shall notify the insurer whether the RBC Plan shall be implemented or is, in the judgment of the Commissioner, unsatisfactory. If the Commissioner determines the RBC Plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination, and may set forth proposed revisions which will render the RBC Plan satisfactory. Upon notification from the Commissioner, the insurer shall prepare a Revised RBC Plan, which may incorporate by reference any revisions proposed by the Commissioner, and shall submit the Revised RBC Plan to the Commissioner within 45 days after the notification from the Commissioner; or if the insurer challenges the notification from the Commissioner under § 31–2007, within 45 days after a notification to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

(e) In the event of a notification by the Commissioner to an insurer that the insurer's RBC Plan or Revised RBC Plan is unsatisfactory, the Commissioner may at the Commissioner's discretion, subject to the insurer's right to a hearing under § 31–2007, specify in the notification that the notification constitutes a Regulatory Action Level Event as defined in § 31–2004.

(f) Every domestic insurer that files an RBC Plan or Revised RBC Plan with the Commissioner shall file a copy of the RBC Plan or Revised RBC Plan with the insurance commissioner in any state in which the insurer is authorized to do business if:

(1) Such state has a RBC provision substantially similar to § 31–2008(a); and

(2) The insurance commissioner of that state has notified the insurer of its request for the filing in writing, in which case the insurer shall file a copy of the RBC Plan or Revised RBC Plan in that state no later than the later of:

(A) Fifteen days after the receipt of notice to file a copy of its RBC Plan or Revised RBC Plan with the state; or

(B) The date on which the RBC Plan or Revised RBC Plan is filed under § 31–2003(c) and (d).

(Apr. 9, 1997, D.C. Law 11–233, § 4, 44 DCR 765; Mar. 14, 2012, D.C. Law 19–103, § 3, 59 DCR 432.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 19–103, in subsec. (a)(1), deleted "and" from the end of subpar. (A), substituted "; or " for a period the end of subpar. (B), and added subpar. (C).

Legislative History of Laws

For history of Law 19–103, see notes under § 31–3931.03.

Chapter 22A

Unfair Insurance Trade Practices.

Section

31–2231.11. Unfair discrimination.
31–2231.24. Judicial review.

§ 31–2231.11. Unfair discrimination.

(a) No person shall commit or permit any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for a life insurance policy or contract, in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the policy or contract.

(b) No person shall commit or permit any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, fees, or rates charged for a policy or contract of accident or health insurance; in the benefits payable under a policy or contract of accident or health insurance; in any of the terms or conditions of the policy or contract of accident or health insurance; or in any other manner. This section shall not prohibit a fee or charge for insurance premium payment plans, regardless of the number of installments involved.

(b–1) For the purposes of subsections (a) and (b) of this section, no person shall inquire, directly or indirectly, as to whether an insured or applicant is, or has been, the victim of an intrafamily offense, sexual assault, dating violence, or stalking, or make use of information as to an insured or applicant's status as a victim of an intrafamily offense, sexual assault, dating violence, or stalking; provided, that this subsection shall not prohibit a person from asking about a medical condition or from using medical information to underwrite or to carry out its duties under a policy, even if the medical information is related to a medical condition that the person knows or has reason to know is related to an intrafamily offense, sexual assault, dating violence, or stalking, to the extent otherwise permitted under this chapter or applicable law. For purposes of this subsection, the term "intrafamily offense" shall have the same meaning as provided in § 16–1001(8).

(c) No person shall refuse to insure, refuse to continue to insure, or limit the amount of coverage available to an individual because of marital status, race, color, personal appearance, sexual orientation, gender identity or expression, matriculation, political affiliation, or an individual's status as a victim of an intrafamily offense, sexual assault, dating violence, or stalking. Nothing in this subsection shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependent benefits or prohibit or limit the operation of fraternal benefit societies. For the purposes of this subsection, the term "matriculation" shall have the same meaning as in § 2–1401.02(18).

(d) No person shall terminate or modify coverage, or refuse to issue or refuse to renew, a property and casualty policy or a life, health, or annuity policy, solely because the applicant or insured, or an employee of either, is mentally or physically impaired. A termination, modification, or refusal shall be based on sound actuarial principles or related to actual or reasonably anticipated experience. This subsection shall not be interpreted to modify any other provision of law relating to the termination, modification, issuance, or renewal of an insurance policy or contract.

(e) No person shall refuse to insure an individual solely because another insurer has refused to write a policy or has cancelled or has refused to renew an existing policy in which the individual was named an insured. This subsection shall not prevent the termination of an excess insurance policy on account of the failure of the insured to maintain any required underlying insurance.

(Apr. 3, 2001, D.C. Law 13–265, § 111, 48 DCR 1225; Oct. 3, 2001, D.C. Law 14–28, § 2702(a), 48 DCR 6981; June 25, 2008, D.C. Law 17–177, § 16(b), 55 DCR 3696; Apr. 8, 2011, D.C. Law 18–360, § 202(a), 58 DCR 896.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 18–360, in subsec. (b), substituted "health insurance" for "health insurance policy", "policy or contract of accident or health insurance " for "contract or policy", and "policy or contract of health insurance" for "policy or contract"; added subsec. (b–1); and, in subsec. (c), substituted "political affiliation, or an individual's status as a victim of an intrafamily offense, sexual assault, dating violence, or stalking" for "or political affiliation".

Legislative History of Laws

Law 18–360, the "Reasonable Health Insurance Ratemaking and Health Care Reform Act of 2010",

was introduced in Council and assigned Bill No. 18–792, which was referred to the Committee on Public Services and Consumer Affairs. The Bill was adopted on first and second readings on November 9, 2010, and December 7, 2010, respectively. Signed by the Mayor on January 20, 2011, it was assigned Act No. 18–710 and transmitted to both Houses of Congress for its review. D.C. Law 18–360 became effective on April 8, 2011.

Miscellaneous Notes

Section 203 of D.C. Law 18–360 provides:

"Sec. 203. Application.

"This title shall apply to policies and certificates of insurance that are health benefit plans as defined under section 2(4) of the Health Insurance Coverage for Habilitative Services for Children Act of 2006, effective March 2, 2007 (D.C. Law 16–198; D.C. Official Code § 31–3271(4)), that are issued 90 days after the effective date of this title. This title shall not apply to short-term limited duration health benefit plans."

§ 31–2231.24. Judicial review.

If, after any hearing under § 31–2231.23, the Commissioner does not find a violation of this chapter, an aggrieved person may, within 60 days after the decision has been issued, or later in connection with § 31–2231.11(a), (b), or (b–1) upon a showing of good cause by a victim of an intrafamily offense, sexual assault, dating violence, or stalking, appeal the decision of the Commissioner to the District of Columbia Court of Appeals. In addition, any person subject to an order of the Commissioner under § 31–2231.22 may obtain a review of the order by filing in the District of Columbia Court of Appeals, within 60 days after the order has been issued, a written petition requesting that the order of the Commissioner be set aside. Except as provided above for the time for filing an appeal, appeals shall be made in accordance with § 2–510.

(Apr. 3, 2001, D.C. Law 13–265, § 124, 48 DCR 1225; Apr. 8, 2011, D.C. Law 18–360, § 202(b), 58 DCR 896.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 18–360 substituted "issued, or later in connection with § 31–2231.11(a), (b), or (b–1) upon a showing of good cause by a victim of an intrafamily offense, sexual assault, dating violence, or stalking, appeal" for "issued, appeal".

Legislative History of Laws

For history of Law 18–360, see notes under § 31–2231.11.

Miscellaneous Notes

Section 203 of D.C. Law 18–360 provides:

"Sec. 203. Application.

"This title shall apply to policies and certificates of insurance that are health benefit plans as defined under section 2(4) of the Health Insurance Coverage for Habilitative Services for Children Act of 2006, effective March 2, 2007 (D.C. Law 16–198; D.C. Official Code § 31–3271(4)), that are issued 90 days after the effective date of this title. This title shall not apply to short-term limited duration health benefit plans."

SUBTITLE III

FIRE, CASUALTY, MARINE, MOTOR VEHICLE AND RELATED INSURANCE.

Chapter 24

Compulsory/No–Fault Motor Vehicle Insurance

Section
31–2406. Availability of required and optional insurance and benefits.
31–2413. Penalties; adjudications.

§ 31–2406. Availability of required and optional insurance and benefits.

Notes of Decisions

7. Coverage

Driver who did not pay to renew automobile insurance policy before its expiration and died in motor vehicle accident the day after the policy expired did not accept insurer's offer of coverage,

and, thus, no policy was in effect at time of accident, although insurer customarily allowed its insureds seven-day grace period, and driver had history of making late payments under his prior policies with insurer; customers were not informed of period, there was no evidence that driver knew of it, it was only available to those who actually made payment within the period, and driver's death did not allow court to speculate that driver would have paid within the period had he lived. Andrade-Sorto v. Allstate Ins. Co., 2009, 982 A.2d 669. Insurance ⟹ 1896; Insurance ⟹ 1902

§ 31–2413. Penalties; adjudications.

(a) A person is guilty of an offense if that person:

(1) Makes any false material statement with respect to his or her compliance with the obligation to maintain required insurance;

(2) Is the owner of a motor vehicle that is required to be registered or obtain a reciprocity sticker in the District and required insurance is not in effect with respect to that motor vehicle;

(3) Is the owner of a motor vehicle and operates or permits that motor vehicle to be operated in the District without required insurance being in effect with respect to that motor vehicle;

(4) Repealed.

(5) Operates a motor vehicle as to which the certificate of registration or reciprocity sticker has been suspended pursuant to § 31–2403(d)(2);

(6) Fails or refuses to return or give a registration certificate, reciprocity sticker, or tags to the Department, an authorized agent of the Department, or to a law-enforcement officer;

(7) Fails or refuses to present an Insurance Identification Card, its equivalent in another state, or other evidence establishing that required insurance is in effect with respect to a motor vehicle operated by that person upon demand by a law-enforcement officer; or

(8) Violates any other provision of this chapter.

(a–1) A violation of subsection (a)(7) of this section shall create a rebuttable presumption of a violation of subsection (a)(3) of this section.

(b)(1)(A) A person who commits an offense under subsection (a)(3) of this section shall be subject to both the regulatory scheme established in § 31–2403(d)(2) and to a civil fine of $500, or a license suspension for up to 30 days, or both, for the first offense, and an increase of 50% of the civil fine for the second and each subsequent offense, or a license suspension for up to 60 days, or both, pursuant to §§ 50–2301.04 and 50–2301.05.

(B) A motor vehicle owner or operator shall be permitted to contest by mail or in person the charge of operating or permitting to be operated a motor vehicle without required insurance being in effect with respect to that motor vehicle pursuant to subsection (a)(3) of this section. For the purposes of contesting the charge, the owner or operator shall be permitted to present as evidence establishing that the required insurance was in effect with respect to the motor vehicle any of the following:

(i) An Insurance Identification Card;

(ii) An insurance policy;

(iii) Any other evidence that constitutes reasonable proof that the required insurance was in effect; or

(iv) Copies of any documents described in sub-subparagraphs (i) through (iii) of this subparagraph.

(C) Unless the hearing examiner has reasonable doubt about the veracity of the evidence presented pursuant to subparagraph (B)(i) and (ii) of this paragraph, submission of either shall be sufficient to dismiss the charge of operating or permitting to be operated a motor vehicle without required insurance being in effect with respect to that motor vehicle pursuant to subsection (a)(3) of this section.

(2)(A) In addition to the regulatory scheme established in § 31-2403(d)(2) for a person who commits an offense under subsection (a)(2) of this section a civil fine of $150 shall be assessed for each vehicle without the required insurance for a period of 1 to 30 days, and increasing to $7 for each day thereafter, not to exceed a total of $2,500 for each violation pursuant to § 31–2404(d)(2)(A). All or part of any penalty may be waived by the

Director upon submission or proof that the vehicle was not operated during the corresponding time period.

(B) A person shall not be subject to a fine pursuant to this paragraph if the person believed, in good faith, that the person contracted for the required insurance coverage with a company which subsequently went out of business or otherwise failed to comply with this law.

(3) A person who commits an offense under subsection (a)(7) of this section shall be subject both to the regulatory scheme established in § 31–2403(d)(2) and to a civil fine of $30.

(c) In addition to the penalties provided in subsection (b)(1) of this section, a person who commits an offense under subsection (a)(1), (5), (6), or (8) of this section shall upon conviction also be subject to imprisonment for not more than 30 days for the 1st offense, and imprisonment for not more than 90 days for the 2nd and subsequent offenses.

(d) All fines paid for violations of subsection (a) of this section shall be placed in the General Fund of the District of Columbia.

(Sept. 18, 1982, D.C. Law 4–155, § 15, 29 DCR 3491; Mar. 10, 1983, D.C. Law 4–199, § 3, 30 DCR 119; Sept. 27, 1985, D.C. Law 6–38, § 2, 32 DCR 4307; Mar. 4, 1986, D.C. Law 6–96, § 2(m), 32 DCR 7245; Mar. 23, 1995, D.C. Law 10–253, § 103, 42 DCR 721; Sept. 26, 1995, D.C. Law 11–52, § 103, 42 DCR 3684; Apr. 27, 2001, D.C. Law 13–289, § 101(d), 48 DCR 2057; June 8, 2006, D.C. Law 16–117, § 201(c), 53 DCR 2548; Mar. 14, 2007, D.C. Law 16–279, § 204, 54 DCR 903; July 18, 2008, D.C. Law 17–197, § 10(b), 55 DCR 6277; Sept. 14, 2011, D.C. Law 19–21, § 9050(b), 58 DCR 6226.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 19–21, in subsec. (d), substituted "General Fund of the District of Columbia" for "Motor Vehicle Theft Prevention Fund established by § 3–1356".

Legislative History of Laws

For history of Law 19–21, see notes under § 31–107.

Chapter 25

Fire, Casualty, and Marine Insurance.

Subchapter II. Powers and Duties of the Commissioner.

Section
31–2502.28. Rate and form filing requirements for accident and health policies.

Subchapter II. Powers and Duties of the Commissioner.

§ 31–2502.28. Rate and form filing requirements for accident and health policies.

The Commissioner may require that the provisions and conditions contained in any policy of insurance against loss or damage from sickness or bodily injury or death of the insured by accident issued by, and the rate-making and filing obligations of, any company authorized by this chapter to transact business in the District be made to conform to the requirements prescribed under § 31–4712.

(Oct. 9, 1940, 54 Stat. 1076, ch. 792, ch. II, § 28; May 21, 1997, D.C. Law 11–268, § 10(r)(2), 44 DCR 1730; Apr. 8, 2011, D.C. Law 18–360, § 501, 58 DCR 896.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 18–360, in the section heading, substituted "Rate and form filing requirements for" for "Required provisions in"; and substituted "issued by, and the rate-making and filing obligations of," for "issued by".

Legislative History of Laws

For history of Law 18–360, see notes under § 31–2231.11.

SUBTITLE IV
HEALTH AND RELATED INSURANCE.

Chapter 29C
Chemotherapy Pill Coverage.

Section
31–2995.01. Definitions.

Section
31–2995.02. Chemotherapy pill coverage.
31–2995.03. Applicability to group health plans.

§ 31–2995.01. Definitions.

For the purposes of this chapter, the term:

(1) "Group health plan" means an employee welfare plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974, approved September 2, 1974 (88 Stat. 829; 29 U.S.C. § 1002(1)), to the extent that the plan provides medical care and includes items and services paid for as medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(2) "Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and includes items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital, or medical service plan contract, or health maintenance organization contract offered by a health insurer.

(3) "Health insurer" means any person that provides one or more health benefit plans or insurance in the District, including an insurer, a hospital and medical services corporation, a fraternal benefit society, a health maintenance organization, a multiple employer welfare arrangement, or any other person providing a plan of health insurance subject to the authority of the Commissioner of the Department of Insurance, Securities, and Banking.

(4) "Individual health plan" means a plan offering health insurance coverage offered to individuals other than in connection with a group health plan.

(Dec. 17, 2009, D.C. Law 18–98, § 2, 56 DCR 8530.)

Historical and Statutory Notes

Legislative History of Laws

Law 18–98, the "Chemotherapy Pill Coverage Act of 2009", as introduced in Council and assigned Bill No. 18–278, which was referred to the Committee on Public Services and Consumer Affairs. The bill as adopted on first and second readings on September 22, 2009, and October 6, 2009, respectively. Effective without the Mayor's signature on October 21, 2009, it was assigned Act No. 18–225 and transmitted to both Houses of Congress for its review. D.C. Law 18–98 became effective on December 17, 2009.

§ 31–2995.02. Chemotherapy pill coverage.

(a) An individual health plan or group health plan, and a health insurer offering health insurance coverage that provides coverage for prescription drugs, shall provide health insurance coverage for prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells and the person receiving such prescribed medication shall have the option of having it dispensed at any appropriately licensed pharmacy.

(b) The health insurance coverage provided under this section shall be on a basis no less favorable than coverage provided for intravenously administered or injected cancer medications, for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and

coinsurance factors, and benefit year maximum for deductibles and copayments and coinsurance factors.

(Dec. 17, 2009, D.C. Law 18–98, § 3, 56 DCR 8530.)

Historical and Statutory Notes

Legislative History of Laws

For Law 18–98, see notes following § 31–2995.01.

§ 31–2995.03. Applicability to group health plans.

This chapter shall apply to group health plans for years beginning on or after December 17, 2009.

(Dec. 17, 2009, D.C. Law 18–98, § 4, 56 DCR 8530.)

Historical and Statutory Notes

Legislative History of Laws

For Law 18–98, see notes following § 31–2995.01.

Chapter 29D

Dependent Health Insurance.

Section
31–2996.01. Definitions.
31–2996.02. Dependent child coverage.
31–2996.03. Limitations on other coverage.

§ 31–2996.01. Definitions.

For the purposes of this chapter, the term:

(1) "Dependent child" means an insured's child by blood or by law who:

(A) Is under 26 years of age;

(B) Has no dependent of his own;

(C) Is enrolled as a full-time student at an accredited public or private institution of higher education; and

(D) Is not provided coverage, or eligible to receive coverage, as a named subscriber, insured, enrollee, or covered person under any other group health plan or individual health plan, or entitled to benefits under Title XVIII of the Social Security Act, approved July 30, 1965 (Pub. L. No. 89–871; 42 U.S.C. § 1395 *et seq.*), at the time dependent coverage pursuant to this chapter begins.

(2) "Group health plan" means an employee welfare plan (as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974, approved September 2, 1974 (88 Stat. 829; 29 U.S.C. § 1002(1)), to the extent that the plan provides medical care and includes items and services paid for as medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(3) "Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and includes items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurer.

(4) "Health insurer" means any person that provides one or more health benefit plans or insurance in the District, including an insurer, a hospital and medical services corporation, a fraternal benefit society, a health maintenance organization, a multiple employer welfare

arrangement, or any other person providing a plan of health insurance subject to the authority of the Commissioner.

(Oct. 26, 2010, D.C. Law 18–252, § 2, 57 DCR 8064.)

Historical and Statutory Notes

Temporary Addition of Section

Section 2 of D.C. Law 18–203 added a section to read as follows:

"Sec. 2. Definitions.

"For the purposes of this act, the term:

"(1) 'Dependent child' means an insured's child by blood or by law who:

"(A) Is under 26 years of age;

"(B) Is unmarried;

"(C) Has no dependent of his own;

"(D) Is a resident of the District of Columbia or is enrolled as a full-time student at an accredited public or private institution of higher education; and

"(E) Is not provided coverage, or eligible to receive coverage, as a named subscriber, insured, enrollee, or covered person under any other group health plan or individual health plan, or entitled to benefits under Title XVIII of the Social Security Act, approved July 30, 1965 (Pub. L. 89–871; 42 U.S.C. § 1395 *et seq.*), at the time dependent coverage pursuant to this act begins.

"(2) 'Group health plan' means an employee welfare plan (as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974, approved September 2, 1974 (88 Stat. 829; 29 U.S.C. § 1002(1)), to the extent that the plan provides medical care and includes items and services paid for as medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

"(3) 'Health insurance coverage' means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and includes items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital, or medical service plan contract, or health maintenance organization contract offered by a health insurer.

"(4) 'Health insurer' means any person that provides one or more health benefit plans or insurance in the District, including an insurer, a hospital and medical services corporation, a fraternal benefit society, a health maintenance organization, a multiple employer welfare arrangement, or any other person providing a plan of health insurance subject to the authority of the Commissioner of Insurance, Securities, and Banking."

Section 6(b) of D.C. Law 18–203 provides that the act shall expire after 225 days of its having taken effect.

Emergency Act Amendments

For temporary (90 day) addition, see § 2 of Health Insurance for Dependents Emergency Act of 2010 (D.C. Act 18–384, April 29, 2010, 57 DCR 3835).

Legislative History of Laws

Law 18–252 , the "Health Insurance for Dependents Act of 2010", was introduced in Council and assigned Bill No. 18–499, which was referred to the Committee on Public Services and Consumer Affairs. The Bill was adopted on first and second readings on June 29, 2010, and July 13, 2010, respectively. Signed by the Mayor on August 3, 2010, it was assigned Act No. 18–523 and transmitted to both Houses of Congress for its review. D.C. Law 18–252 became effective on October 26, 2010.

§ 31–2996.02. Dependent child coverage.

(a) A group health plan or an individual health plan, and a health insurer offering health insurance coverage that provides coverage for dependent children, that delivers, issues for delivery, amends, or renews a health insurance policy in the District of Columbia shall make health insurance coverage available and, if requested by the policyholder, extend coverage to any dependent child of a policyholder until the dependent child is no longer a dependent child.

(b) The health insurance coverage shall provide:

(1) The same health insurance coverage benefits to a dependent child that are available to any other covered dependent; and

(2) Health insurance coverage benefits to a dependent child at the same rate or premium applicable to any other covered dependent.

(c) Nothing in this chapter shall be construed to require:

(1) Coverage for services provided to a dependent before October 26, 2010; or

(2) That an employer or other group policyholder pay all or part of the cost of coverage for a dependent as provided pursuant to this section.

(Oct. 26, 2010, D.C. Law 18–252, § 3, 57 DCR 8064.)

Historical and Statutory Notes

Temporary Addition of Section

Section 3 of D.C. Law 18–203 added a section to read as follows:

"Sec. 3. Dependent child coverage.

"(a) A group health plan or an individual health plan, and a health insurer offering health insurance coverage that provides coverage for dependent children, that delivers, issues for delivery, amends, or renews a health insurance policy in the District of Columbia shall make health insurance coverage available and, if requested by the policyholder, extend health insurance coverage to any dependent child of a policyholder until the dependent child is no longer a dependent child.

"(b) The health insurance coverage shall provide:

"(1) The same health insurance coverage benefits to a dependent child that are available to any other covered dependent; and

"(2) Health insurance coverage benefits to a dependent child at the same rate or premium applicable to any other covered dependent.

"(c) Nothing in this act shall be construed to require:

"(1) Coverage for services provided to a dependent before the effective date of this act; or

"(2) That an employer or other group policyholder pay all or part of the cost of coverage for a dependent as provided pursuant to this section."

Section 6(b) of D.C. Law 18–203 provides that the act shall expire after 225 days of its having taken effect.

Emergency Act Amendments

For temporary (90 day) addition, see § 3 of Health Insurance for Dependents Emergency Act of 2010 (D.C. Act 18–384, April 29, 2010, 57 DCR 3835).

Legislative History of Laws

For history of Law 18–252, see notes under § 31–2996.01.

§ 31–2996.03. Limitations on other coverage.

This chapter shall not limit or alter any right to dependent coverage or to the continuation of coverage that is otherwise provided for in the District of Columbia.

(Oct. 26, 2010, D.C. Law 18–252, § 4, 57 DCR 8064.)

Historical and Statutory Notes

Temporary Addition of Section

Section 4 of D.C. Law 18–203 added a section to read as follows:

"Sec. 4. Limitations on other coverage.

"This act shall not limit or alter any right to dependent coverage or to the continuation of coverage that is otherwise provided for in the District of Columbia."

Section 6(b) of D.C. Law 18–203 provides that the act shall expire after 225 days of its having taken effect.

Emergency Act Amendments

For temporary (90 day) addition, see § 4 of Health Insurance for Dependents Emergency Act of 2010 (D.C. Act 18–384, April 29, 2010, 57 DCR 3835).

Legislative History of Laws

For history of Law 18–252, see notes under § 31–2996.01.

Chapter 30A

Discontinuance of Class of Health Insurance Policies.

Section
31–3011. Conditions for discontinuance of class of health insurance policies.
31–3012. Rules.
31–3013. Application.

§ 31–3011. Conditions for discontinuance of class of health insurance policies.

(a) If an insurer decides to discontinue a particular class of group, or blanket policy of, hospital, surgical, or medical expense insurance offered in the small or large group market, the policy of the class may be discontinued by the insurer only if:

(1) The insurer requests in such form as designated by the Commissioner of the Department of Insurance, Securities, and Banking ("Commissioner") that the Commissioner approve the discontinuance, and the insurer receives the approval; provided, that the Commissioner shall:

(A) No sooner than 60 days after receipt of the request, grant the approval only if he or she determines that the discontinuance of the coverage of this class by the insurer is not with the intent, or as a pretext, to discontinue the coverage of any policyholder or any insured due to the claims experience or any health status-related factor relating to any policyholder or insured covered by any such policy; and

(B) Make the determination only after examining and taking into consideration the claim histories and premium rates for each policy in the class, historical profits and losses for the class of policies, comments from policyholders or others submitted to the Commissioner within 30 days after receipt of any such request, and any other information or analysis the Commissioner demands or considers relevant;

(2) The insurer, no later than the date that the request to the Commissioner under paragraph (2) of this subsection is made, provides written notice to each policyholder of this class in such market (and to all participants and beneficiaries covered under the coverage) of:

(A) The request;

(B) The earliest possible date that the Commissioner might approve the request;

(C) The earliest possible date that the coverage could be discontinued; and

(D) A statement written in plain English of the obligations of the insurer and the rights of policyholders; and

(3) The insurer, upon approval by the Commissioner of any such request:

(A) Provides written notice to each policyholder provided coverage of the class in the market (and to all participants and beneficiaries covered under the coverage) of the discontinuance at least 90 days prior to the date of discontinuance of the coverage;

(B) Offers to each policyholder of this class in the market, the option to purchase all (or, in the case of the large group market, any) other hospital, surgical, and medical expense coverage currently being offered by the insurer to a group in the market; and

(C) In exercising the option to discontinue coverage of the class and in offering the option of coverage under another class, acts uniformly without regard to the claims experience of those policyholders or any health status-related factor relating to any insureds covered, or new insureds who may become eligible, for the coverage.

(b) If an insurer discontinues a particular class of group, or blanket policy of, hospital, surgical, or medical expense insurance offered in the small or large group market, other than where the Commissioner authorizes the discontinuance, the insurer shall be liable to the former holder or beneficiary of such policy, or to his or her estate, for compensatory damages arising from the discontinuance, plus costs and reasonable attorneys' fees, in an action which shall be commenced no later than 3 years after the date of the discontinuance. In any such action, the court may grant such injunctive relief as the court may consider proper.

(c) If major medical insurance or insurance providing major medical type benefits is discontinued, the Commissioner shall order that an extended benefit shall be provided during total disability, with respect to the sickness, injury, or pregnancy which caused the disability, of at least 18 months subsequent to the discontinuance of the insurance unless similar coverage is afforded for the total disability under another group plan.

(Apr. 8, 2011, D.C. Law 18–360, § 402, 58 DCR 896.)

Historical and Statutory Notes

Legislative History of Laws

Law 18–360, the "Reasonable Health Insurance Ratemaking and Health Care Reform Act of 2010", was introduced in Council and assigned Bill No. 18–792, which was referred to the Committee on Public Services and Consumer Affairs. The Bill was adopted on first and second readings on November 9, 2010, and December 7, 2010, respectively. Signed by the Mayor on January 20, 2011, it was assigned Act No. 18–710 and transmitted to both Houses of Congress for its review. D.C. Law 18–360 became effective on April 8, 2011.

§ 31–3012. Rules.

The Mayor, pursuant to subchapter I of Chapter 5 of Title 2, shall issue rules to implement the provisions of this chapter.

(Apr. 8, 2011, D.C. Law 18–360, § 403, 58 DCR 896.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 18–360, see notes under § 31–3011.

§ 31–3013. Application.

This chapter shall apply to policies and certificates of insurance that are health benefit plans as defined under § 31–3271(4) that are issued 90 days after April 8, 2011. This chapter shall not apply to short-term limited duration health benefit plans.

(Apr. 8, 2011, D.C. Law 18–360, § 404, 58 DCR 896.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 18–360, see notes under § 31–3011.

Chapter 31C

Health Benefit Plans Equity.

Section		Section	
31–3161.	Prohibition on gender-based discrimination in rate making.	31–3162.	Rules.
		31–3163.	Application.

§ 31–3161. Prohibition on gender-based discrimination in rate making.

(a) For the purposes of this section, the term "health benefit plan" shall have the same meaning as provided in § 31–3001(1).

(b) An individual health benefit plan offered, sold, issued, or renewed to a District resident shall not have a premium rate, or any other underwriting decision, determined through a method that is in any way based upon the gender or sex of a person covered under the health benefit plan.

(c) Each individual health benefit plan offered, sold, issued, or renewed in the District shall provide hospitalization benefits for childbirth to the same extent as benefits provided in the policy for any covered illness. In addition to the provisions of this subsection and subsection (c) of this section, if a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the hospital, the individual health benefit plan shall pay the cost of additional hospitalization for the newborn for up to 4 days.

(d) Each individual health benefit plan offered, sold, issued, or renewed in the District shall provide coverage for the cost of inpatient hospitalization services for a mother and newborn child for a minimum of:

(1) Forty–eight hours of inpatient hospitalization care after an uncomplicated vaginal delivery; and

(2) Ninety–six hours of inpatient hospitalization care after an uncomplicated cesarean section.

(e) A mother may request a shorter length of stay than that provided in subsection (c) of this section if the mother decides, in consultation with the mother's attending provider, that less time is needed for recovery.

(f)(1) For a mother and newborn child who have a shorter hospital stay than that provided under subsection (c) of this section, the individual health benefit plan shall provide coverage for:

(A) One home visit scheduled to occur within 24 hours after hospital discharge; and

(B) An additional home visit if prescribed by the mother's attending provider.

(2) For a mother and newborn child who remain in the hospital for at least the length of time provided under subsection (c) of this section, the individual health benefit plan shall provide coverage for a home visit if prescribed by the mother's attending provider.

(3) A home visit under paragraph (1) or (2) of this subsection shall:

(A) Be provided in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child;

(B) Be provided by a registered nurse with at least one year of experience in maternal and child health nursing or community health nursing with an emphasis on maternal and child health; and

(C) Include any services required by the mother's attending provider.

(Apr. 8, 2011, D.C. Law 18–360, § 302, 58 DCR 896.)

Historical and Statutory Notes

Legislative History of Laws

Law 18–360, the "Reasonable Health Insurance Ratemaking and Health Care Reform Act of 2010", was introduced in Council and assigned Bill No. 18–792, which was referred to the Committee on Public Services and Consumer Affairs. The Bill was adopted on first and second readings on November 9, 2010, and December 7, 2010, respectively. Signed by the Mayor on January 20, 2011, it was assigned Act No. 18–710 and transmitted to both Houses of Congress for its review. D.C. Law 18–360 became effective on April 8, 2011.

§ 31–3162. Rules.

The Mayor, pursuant to subchapter I of Chapter 5 of Title 2, shall issue rules to implement the provisions of this chapter.

(Apr. 8, 2011, D.C. Law 18–360, § 303, 58 DCR 896.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 18–360, see notes under § 31–3161.

§ 31–3163. Application.

This chapter shall apply to policies and certificates of insurance that are health benefit plans as defined under § 31–3271(4) that are issued 90 days after April 8, 2011. This chapter shall not apply to short-term limited duration health benefit plans.

(Apr. 8, 2011, D.C. Law 18–360, § 304, 58 DCR 896.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 18–360, see notes under § 31–3161.

Chapter 31D

Health Benefit Exchange.

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Section
31–3171.18. Applicability.

§ 31–3171.01. Definitions.

For the purposes of this chapter, the term:

(1) "American Health Benefit Exchange" means an entity established pursuant to § 31–3171.04 , and section 1311(b) of the Federal Act.

(2) "Authority" means the District of Columbia Health Benefit Exchange Authority established by § 31–3171.02.

(3) "Commissioner" means the Commissioner of the Department of Insurance, Securities and Banking, as established by § 31–102.

(4) "Federal Act" means the Patient Protection and Affordable Care Act, approved March 23, 2010 (124 Stat. 119; 42 U.S.C. § 18001, note), as amended by the Health Care and Education Reconciliation Act of 2010 approved March 30, 2010 (124 Stat. 1029; 42 U.S.C. § 1305, note), and any amendments, regulations, or guidance issued pursuant to the Federal Act.

(5)(A) "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(B) The term "health benefit plan" does not include:

(i) Coverage only for accident or disability income insurance, or any combination thereof;

(ii) Liability insurance, including general liability insurance and automobile liability insurance;

(iii) Coverage issued as a supplement to liability insurance;

(iv) Workers' compensation or similar insurance;

(v) Automobile medical payment insurance;

(vi) Credit–only insurance;

(vii) Coverage for on-site medical clinics; or

(viii) Other similar insurance coverage, specified in federal regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, approved August 21, 1996 (110 Stat. 1936; 42 U.S.C. § 201, note) ("HIPAA"), under which benefits for health care services are secondary or incidental to other insurance benefits.

(C) The term "health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate of insurance, or contract of insurance, or are otherwise not an integral part of the plan:

(i) Limited scope dental or vision benefits;

(ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(iii) Other similar, limited benefits specified in federal regulations issued pursuant to HIPAA.

(D) The term "health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate of insurance, or contract of insurance, and there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(i) Coverage only for a specified disease or illness; or

(ii) Hospital indemnity or other fixed indemnity insurance.

(E) The term "health benefit plan" does not include the following if offered as a separate policy, certificate of insurance, or contract of insurance:

(i) A Medicare supplemental policy as defined in section 1882(g)(1) of the Social Security Act (42 U.S.C. § 1395ss(g)(1));

(ii) Coverage supplemental to the coverage provided under 10 U.S.C. § 1071 *et seq.*; or

(iii) Similar supplemental coverage provided to coverage under a group health plan.

(6) "Health carrier" means an entity subject to the insurance laws and regulations of the District that contracts, or offers to contract, to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including:

(A) An accident and sickness insurance company;

(B) A health maintenance organization;

(C) A hospital and medical services corporation; or

(D) Any other entity providing a health benefit plan.

(7) "Health professional" shall have the same meaning as provided in § 3–1201.01(8).

(8) "Internal Revenue Code of 1986" means the Internal Revenue Code of 1986, approved August 16, 1954 (100 Stat. 2095; 26 U.S.C. § 1 *et seq.*).

(9) "PHSA" means the Public Health Service Act, approved July 1, 1944 (58 Stat. 682; 42 U.S.C. § 201 *et seq.*).

(10) "Qualified dental plan" means a limited-scope dental plan that has been certified in accordance with § 31–3171.09.

(11) "Qualified employer" means a small employer that elects to make its full-time employees eligible for one or more qualified health plans offered through the Small Business Health Options Program Exchange ("SHOP Exchange"), and, at the option of the employer, some or all of its part-time employees; provided, that the employer:

(A) Has its principal place of business in the District and elects to provide coverage through the SHOP Exchange to all of its eligible employees, wherever employed; or

(B) Elects to provide coverage through the SHOP Exchange to all of its eligible employees who are principally employed in the District.

(12) "Qualified health plan" means a health benefit plan that has a certification validating that the plan meets the criteria for certification described in section 1311(c) of the Federal Act and § 31–3171.09.

(13) "Qualified individual" means an individual, including a minor, who:

(A) Is seeking to enroll in a qualified health plan offered to individuals through the Authority;

(B) Resides in the District;

(C) At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and

(D) Is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

(14) "Secretary" means the Secretary of the United States Department of Health and Human Services.

(15) "SHOP Exchange" means a Small Business Health Options Program Exchange established pursuant to § 31–3171.04, and section 1311(b) of the Federal Act.

(16)(A) "Small employer" means a single employer that employed an average of not more than 50 employees during the preceding calendar year.

(B) For the purposes of this paragraph:

(i) All persons treated as a single employer under section 414(b), (c), (m), or (o) of the Internal Revenue Code of 1986 (26 U.S.C. § 414(b), (c), (m), or (o)) shall be treated as a single employer.

(ii) An employer and any predecessor employer shall be treated as a single employer.

(iii) All employees shall be counted, including part-time employees and employees who are not eligible for health benefit coverage through the employer.

(iv) If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the

average number of employees that employer is reasonably expected to employ in the current calendar year.

(v) An employer that makes enrollment in qualified health plans available to its employees through the SHOP Exchange and would cease to be a small employer by reason of an increase in the number of its employees shall continue to be treated as a small employer for purposes of this chapter as long as it continuously makes enrollment through the SHOP Exchange available to its employees.

(17) "Social Security Act" means the Social Security Act, approved August 14, 1935 (49 Stat. 620; 42 U.S.C. § 301 *et seq.*), as amended.

(Mar. 2, 2012, D.C. Law 19–94, § 2, 59 DCR 213.)

Historical and Statutory Notes

Legislative History of Laws

Law 19–94, the "Health Benefit Exchange Authority Establishment Act of 2011", was introduced in Council and assigned Bill No. 19–2, which was referred to the Committee on Health, Public Services and Consumer Affairs. The Bill was adopted on first and second readings on December 2, 2012, and December 20, 2012, respectively. Signed by the Mayor on January 17, 2012, it was assigned Act No. 19–269 and transmitted to both Houses of Congress for its review. D.C. Law 19–94 became effective on March 2, 2012.

§ 31–3171.02. Establishment and purpose.

(a) There is established, as an independent authority of the District government, the District of Columbia Health Benefit Exchange Authority. The Authority shall be an instrumentality, created to effectuate the purposes stated in this chapter, that shall have a legal existence separate from the District government.

(b) The purposes of the Authority shall be to:

(1) Enable individuals and small employers to find affordable and easier-to-understand health insurance;

(2) Facilitate the purchase and sale of qualified health plans;

(3) Assist small employers in facilitating the enrollment of their employees in qualified health plans;

(4) Reduce the number of uninsured;

(5) Provide a transparent marketplace for health benefit plans;

(6) Educate consumers; and

(7) Assist individuals and groups to access programs, premium assistance tax credits, and cost-sharing reductions.

(Mar. 2, 2012, D.C. Law 19–94, § 3, 59 DCR 213.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 19–94, see notes under § 31–3171.01.

§ 31–3171.03. District of Columbia Health Benefit Exchange Authority Fund.

(a) There is established as a nonlapsing fund the District of Columbia Health Benefit Exchange Authority Fund ("Fund"), which shall be administered by the Authority in accordance with generally accepted accounting principles and which shall be used solely for the purposes set forth in this chapter and the costs of administering this chapter.

(b) The Fund shall consist of:

(1) Any user fees, licensing fees, or other assessments collected by the Authority;

(2) Income from investments made on behalf of the Fund;

(3) Interest on money in the Fund;

(4) Money collected by the executive board as a result of a legal or other action;

(5) Donations;

(6) Grants;

(7) All general revenue funds appropriated by a line item in the budget submitted pursuant to § 1–204.46, and authorized by Congress for the purposes of the Authority; and

(8) Any other money from any other source accepted for the benefit of the Fund.

(c) All revenues, income from investments, proceeds, and other monies, from whatever source derived, that are collected or received by the Authority shall be deposited into the Fund. All funds deposited into the Fund, and any interest earned on those funds, shall not revert to the unrestricted fund balance of the General Fund of the District of Columbia at the end of a fiscal year, or at any other time, but shall be continually available for the uses and purposes set forth in this chapter without regard to fiscal year limitation, subject to authorization by Congress.

(d) The Chief Financial Officer shall invest the money of the Fund in the same manner as other District money may be invested.

(e)(1) The Authority is authorized to charge, through rulemaking:

(A) User fees;

(B) Licensing fees; and

(C) Other assessments on health carriers selling qualified dental plans or qualified health plans in the District, including qualified health plans and qualified dental plans sold outside the exchanges.

(2) User fees, licensing fees, or other assessments authorized shall not exceed reasonable projections regarding the amount necessary to support the operations of the Authority.

(Mar. 2, 2012, D.C. Law 19–94, § 4, 59 DCR 213.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 19–94, see notes under § 31–3171.01.

§ 31–3171.04. Authority duties and powers.

(a) The Authority shall:

(1) Establish the American Health Benefit Exchange to assist qualified individuals in the District with enrollment in qualified health plans;

(2) Establish a SHOP Exchange through which qualified employers may access coverage for their employees and shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the SHOP Exchange at the specified level of coverage;

(3) Certify plans as qualified health plans as set forth in § 31–3171.09 and make such plans available to qualified individuals and qualified employers, as required by the Federal Act, with effective dates on January 1, 2014; provided, that the Authority shall not make available any health benefit plan that is not a qualified health plan.

(4) Have independent personnel authority to hire, retain, and terminate personnel as appropriate to perform the functions of the Authority consistent with Chapter 6 of Title 1, including establishing compensation and reimbursement consistent with the District's wage grade and non-wage grade schedules;

(5) Have procurement authority independent of the Office of Contracting and Procurement, consistent with Chapter 3A of Title 2; except, that § 2–352.02(a), (b), (c), and (e) shall apply.

(6) Publish the average costs of licensing, regulatory fees, and any other payments required by the Authority, and the administrative costs of the Authority, on a website that is publically accessible, to educate consumers on these costs. This information shall include information on monies lost to waste, fraud, and abuse;

(7) Implement procedures for certification, recertification, and decertification, consistent with guidelines developed by the Secretary under section 1311(c) of the Federal Act and of this chapter, of health benefit plans as qualified health plans;

(8) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance, utilizing staff who are trained to provide assistance in a culturally and linguistically appropriate manner;

(9) Provide for enrollment periods, as provided under section 1311(c)(6) of the Federal Act;

(10) Maintain a publically accessible website, through which enrollees and prospective enrollees of qualified health plans and dental plans may obtain standardized comparative information, including on health plan quality and performance, for such plans;

(11) Assign a rating to each qualified health plan offered through the exchanges in accordance with the criteria developed by the Secretary under section 1311(c)(3) of the Federal Act, and determine each qualified health plan's level of coverage in accordance with regulations issued by the Secretary under section 1302(d)(2)(A) of the Federal Act;

(12) Use a standardized format for presenting health benefit options in the exchanges, including the use of the uniform outline of coverage established under section 2715 of the PHSA;

(13) Conduct eligibility determinations, in accordance with section 1413 of the Federal Act for the Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance Program under title XXI of the Social Security Act, or any other applicable District program pursuant to the policies and procedures established by the Department of Health Care Finance;

(14) Establish and make available, through a website that is publicly available, a calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 of the Federal Act, and, if feasible, which is designed to provide consumers with information on out-of-pocket costs for in-network and out-of-network services, taking into account any cost-sharing reductions;

(15) Grant a certification, subject to section 1411 of the Federal Act, attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because:

(A) There is no affordable qualified health plan available through the exchanges, or the individual's employer, covering the individual; or

(B) The individual meets the requirements for another exemption from the individual responsibility requirement or penalty;

(16) Transfer to the Secretary of the United States Department of the Treasury the following:

(A) A list of the individuals who are issued a certification under paragraph (15) of this subsection, including the name and taxpayer identification number of each individual;

(B) The name and taxpayer identification number of each individual who was an employee of an employer who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because the employer:

(i) Did not provide minimum essential coverage; or

(ii) Provided the minimum essential coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code of 1986 to either be unaffordable to the employee or did not provide the required minimum actuarial value; and

(C) The name and taxpayer identification number of:

(i) Each individual who notifies the Authority under section 1411(b)(4) of the Federal Act that he or she has changed employers; and

(ii) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

(17) Provide to each employer the name of each employee of the employer described in paragraph (16)(B) of this subsection who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

(18) Perform the duties required of the Authority by the Secretary, or the Secretary of the United States Department of the Treasury, related to determining eligibility for:

(A) Premium tax credits;

(B) Reduced cost-sharing; or

(C) Individual responsibility requirement exemptions;

(19) Select entities qualified to serve as Navigators in accordance with section 1311(i) of the Federal Act, and standards developed by the Secretary, and award grants to enable Navigators to:

(A) Conduct public education activities to raise awareness of the availability of qualified health plans and qualified dental plans;

(B) Distribute fair and impartial information concerning enrollment in qualified health plans and qualified dental plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the Federal Act;

(C) Facilitate enrollment in qualified health plans and qualified dental plans;

(D) Provide referrals to an office of health insurance consumer assistance or health insurance ombudsman, including the Office of Health Care Ombudsman and Bill of Rights, or any other appropriate District agency, for any enrollee with a grievance or question regarding his or her health benefit plan, coverage, or a determination under that plan or coverage; and

(E) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchanges;

(20) Review the rate of premium growth within and outside the exchanges and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers;

(21) Consult with stakeholders relevant to carrying out the activities required under this chapter, including:

(A) Educated health care consumers who are enrollees in qualified health plans or qualified dental plans;

(B) Individuals and entities with experience in facilitating enrollment in qualified health plans or dental plans;

(C) Representatives of small businesses and self-employed individuals;

(D) The Department of Health Care Finance;

(E) Individuals who have experience enrolling difficult-to-reach populations in public insurance programs;

(F) Public health experts;

(G) Health care providers; and

(H) Office of Health Care Ombudsman and Bill of Rights;

(22) Meet the following financial integrity requirements:

(A) Keep an accurate accounting of all activities, receipts, and expenditures and annually submit to the Secretary, Mayor, Council, and the Commissioner a report of the accountings;

(B) Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the Federal Act;

(C) Allow the Secretary, in coordination with the Inspector General of the United States Department of Health and Human Services, to:

(i) Investigate the affairs of the Authority;

(ii) Examine the properties and records of the Authority; and

(iii) Require periodic reports in relation to the activities undertaken by the Authority; and

(D) In carrying out its activities under this chapter, not use any funds intended for the administrative and operational expenses of the Authority for:

(i) Staff retreats;

(ii) Promotional giveaways;

(iii) Excessive executive compensation; or

(iv) Promotion of federal or District legislative and regulatory modifications not contemplated under the Federal Act.

(b) In addition to certifying qualified health plans, the Authority shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the exchanges, either separately

or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the Federal Act.

(c) Neither the Authority nor a health carrier offering qualified health plans through the exchanges may charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become unaffordable under the standards of section 36B(c)(2)(C) of the Internal Revenue Code of 1986.

(d) The operations of the Authority are subject to the provisions of this chapter whether the operations are performed directly by the Authority or through an entity under a contract with the Authority.

(Mar. 2, 2012, D.C. Law 19–94, § 5, 59 DCR 213.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 19–94, see notes under § 31–3171.01.

§ 31–3171.05. Executive board establishment and membership.

(a) There is established an executive board to govern the Authority consisting of:

(1) Seven voting members, who shall be residents of the District of Columbia, appointed by the Mayor, with the advice and consent of the Council pursuant to § 1–523.01(f).

(2) Four nonvoting, ex-officio members, or their designees, who shall be the:

(A) Director of the Department of Health Care Finance;

(B) Commissioner of the Department of Insurance, Securities and Banking;

(C) Director of the Department of Health; and

(D) Director of the Department of Human Services.

(b)(1) Members of the executive board, other than an ex-officio member, shall be appointed for a term of 4 years, except that for the initial appointments:

(A) Two shall be for a term of 2 years;

(B) One shall be for a term of 3 years;

(C) Two shall be for a term of 4 years; and

(D) Two shall be for a term of 5 years.

(2)(A) A member of the executive board may continue to serve until his or her successor has been approved by the Council and appointed by the Mayor.

(B) Vacancies shall be filled by Mayoral appointment for the unexpired term in the same manner of the original appointment.

(C) A member of the executive board, upon findings by the Mayor, may be removed for incompetence, misconduct, or failure to perform the duties of the position.

(c)(1) Each person appointed to the executive board as a voting member shall have demonstrated and acknowledged expertise in at least 2 of the following areas:

(A) Individual or small employer health care coverage;

(B) Health benefits plan administration;

(C) Health care finance;

(D) Administering a public or private health care delivery system;

(E) Purchasing health plan coverage;

(F) Prior experience in commercial insurance management;

(G) Actuarial analysis;

(H) Health care economics;

(I) Human services administration;

(J) Health care consumer interest advocacy;

(K) Public health programs; or

(L) Enrolling individuals into health benefit plans.

(2) The Mayor shall consider the expertise of each of the members of the executive board and attempt to make appointments so that the executive board's composition reflects a diversity of expertise.

(3) At least one voting member of the executive board shall have demonstrated knowledge in health care consumer interest advocacy.

(d) Each member of the executive board shall have the responsibility and duty to meet the requirements of this chapter, the Federal Act, and all applicable District and federal laws and regulations, to serve the public interest of the individuals and small businesses seeking health care coverage through the exchanges, and to ensure the operational effectiveness and fiscal solvency of the Authority.

(e) The executive board shall elect a chairperson on an annual basis.

(f) Executive board members shall receive no compensation for their services but shall receive actual and necessary expenses incurred in the performance of their official duties.

(g) The Mayor shall nominate a majority of the executive board members within 90 days of March 2, 2012.

(Mar. 2, 2012, D.C. Law 19–94, § 6, 59 DCR 213.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 19–94, see notes under § 31–3171.01.

§ 31–3171.06. Powers and duties of executive board.

(a) Subject to any limitations under this chapter, or other applicable law, the executive board shall have all the powers necessary to carry out the functions authorized by the Federal Act and consistent with the purposes of the Authority.

(b) The enumeration of specific powers in this chapter is not intended to restrict the executive board's power to take any lawful action that it determines is necessary to carry out the functions authorized by the Federal Act and is consistent with the purposes of the Authority.

(c) In addition to the powers set forth elsewhere in this chapter, the executive board may:

(1) Adopt and alter an official seal;

(2) Sue, be sued, plead, and be impleaded;

(3) Adopt bylaws, rules, and policies;

(4) Maintain an office in the District at a place designated by the executive board;

(5) Enter into any agreements or contracts and execute the instruments necessary to manage its affairs and to carry out the purposes of this chapter;

(6) Apply for and receive grants, contracts, or other public or private funding; and

(7) Do all things necessary in conformity with the law to exercise the powers granted by this chapter.

(d)(1) To carry out the purposes of this chapter or perform any of its functions under this chapter, the executive board may contract or enter into memoranda of understanding with eligible entities, including the:

(A) Department of Health Care Finance;

(B) Department of Human Services;

(C) Department of Insurance, Securities and Banking;

(D) Insurance producers and third-party administrators registered in the District; and

(E) Any other entities that have experience in individual and small group public and private health insurance plans or in facilitating enrollment in those plans.

(2) The executive board shall ensure that any entity under a contract with the Authority complies with the provisions of this chapter when performing services on behalf of the Authority that are subject to this chapter.

(e)(1) The executive board may enter into information-sharing agreements with federal agencies, District agencies, agencies of one or more states, and other state health insurance exchanges to carry out the provisions of this chapter.

(2) An information-sharing agreement entered into under paragraph (1) of this subsection shall:

(A) Include adequate protections with respect to the confidentiality of information; and

(B) Comply with all District and federal laws and regulations.

(f) The executive board shall adopt written policies and procedures governing all procurements of the Authority.

(g) The executive board may limit the number of plans offered in the exchanges using selective criteria or contracting; provided, that individuals and employers have an adequate number and selection of choices.

(h) The executive board may merge the exchanges for individual coverage within the American Health Benefits Exchange and the SHOP Exchange if a merger is considered by the Authority to be in the best interest of the District.

(Mar. 2, 2012, D.C. Law 19–94, § 7, 59 DCR 213.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 19–94, see notes under § 31–3171.01.

§ 31–3171.07. Advisory board.

(a) In addition to the executive board, there shall be a standing advisory board consisting of 9 members, who shall be residents of the District.

(b) The executive board may create additional advisory boards as it considers appropriate.

(c) The executive board shall solicit the recommendations of, and consult with, the advisory boards on:

(1) Insurance standards;

(2) Covered benefits;

(3) Premiums;

(4) Plan certification;

(5) Internet technology system development; and

(6) Any other policy or operational issues, within the executive board's discretion.

(d) The executive board shall:

(1) Select the members of the advisory boards;

(2) Establish the terms of the members;

(3) Ensure that at least one member of the standing advisory board demonstrates expertise as a health insurance broker or agent;

(4) Appoint the chair of the standing advisory board;

(5) Determine the residency requirement of any additional advisory board created; and

(6) Appoint the chair of any additional advisory boards created.

(e)(1) An advisory board member may continue to serve until the appointment of his or her successor.

(2) Vacancies shall be filled by appointment by the executive board for the unexpired term of the appointee's predecessor.

(f) Each person appointed to an advisory board shall have demonstrated and acknowledged expertise on issues related to at least one of the following groups:

(1) Health professionals;

(2) Health insurance consumers;

(3) Disease and demographic-specific advocacy groups;

(4) Commercial sector health plans;
(5) Public sector health plans;
(6) Health insurance brokers;
(7) Health care consumer interest advocacy;
(8) Health care foundations;
(9) Exchange consumers; or
(10) Such other interests considered necessary.

(Mar. 2, 2012, D.C. Law 19–94, § 8, 59 DCR 213.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 19–94, see notes under § 31–3171.01.

§ 31–3171.08. Executive director and Authority staff.

(a) The executive board shall hire an executive director within 60 days of a majority of executive board members being confirmed to organize, administer, and manage the operations of the Authority.

(1) The executive director shall not be an employee in the career service and shall serve at the pleasure of the executive board.

(2) The executive director shall become a resident of the District within 180 days of the date of hire.

(b) The executive board shall determine the appropriate compensation for the executive director; provided, that the executive director's compensation shall not exceed the maximum allowable salary in the District of Columbia Excepted Service salary schedule.

(c) Under the direction of the executive board, the executive director shall;

(1) Be the chief administrative officer of the Authority;

(2) Direct, administer, and manage the operations of the Authority; and

(3) Perform all duties necessary to comply with and carry out the provisions of this chapter, other District laws and regulations, and the Federal Act.

(d)(1) The executive director may employ and retain staff for the Authority.

(2) The executive director may retain as independent contractors or employees, and set compensation for:

(A) Attorneys;

(B) Financial consultants; and

(C) Other professionals or consultants necessary to carry out the planning, development, and operations of the Authority and the provisions of this chapter.

(3) Employee compensation shall not exceed the maximum allowable salary in the District of Columbia Excepted Service salary schedule.

(e) Except as otherwise provided in this chapter, an employee or independent contractor of the Authority shall not be subject to any law, regulation or Mayor's Order governing District government compensation, including furloughs, pay cuts, or any other general fund cost-saving measure.

(Mar. 2, 2012, D.C. Law 19–94, § 9, 59 DCR 213.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 19–94, see notes under § 31–3171.01.

§ 31–3171.09. Health benefit plan certification.

(a) To be certified as a qualified health plan, a health benefit plan shall, at a minimum:

(1) Provide the essential health benefits package described in section 1302(a) of the Federal Act; except, that the plan is not required to provide essential benefits that

duplicate the minimum benefits of qualified dental plans, as provided in subsection (e) of this section, if:

(A) The Authority has determined that at least one qualified dental plan is available to supplement the plan's coverage; and

(B) The health carrier makes prominent disclosure at the time it offers the plan, in a form approved by the Authority, that the plan does not provide the full range of essential pediatric dental benefits and that qualified dental plans providing those benefits and other dental benefits not covered by the plan are offered through the exchanges;

(2) Obtain prior approval of premium rates and contract language from the Commissioner;

(3) Provide at least a bronze level of coverage, as determined by § 31–3171.04(a)(11), unless the plan is certified as a qualified catastrophic plan, meets the requirements of section 1302(e) of the Federal Act, and will only be offered to individuals eligible for catastrophic coverage;

(4) Ensure that the cost-sharing requirements of the plan do not exceed the limits established under section 1302(c)(1) of the Federal Act, and if the plan is offered through the SHOP Exchange, the plan's deductible does not exceed the limits established under section 1302(c)(2) of the Federal Act;

(5) Be offered by a health carrier that:

(A) Is licensed and in good standing to offer health insurance coverage in the District;

(B)(i) Offers at least one qualified health plan at the silver level and at least one plan at the gold level through each component of the Authority in which the health carrier participates;

(ii) For the purposes of this subparagraph, the term "component" refers to the SHOP Exchange and the exchange for individual coverage within the American Health Benefit Exchange;

(C) Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the exchanges and without regard to whether the plan is offered directly from the health carrier or through an insurance producer;

(D) Does not charge any cancellation fees or penalties in violation of § 31–3171.04(c); and

(E) Complies with the regulations established by the Secretary under section 1311(d) of the Federal Act and any other requirements as the Authority may establish;

(6) Meet the requirements of certification pursuant to the authority provided in this chapter and by the Secretary under section 1311(c) of the Federal Act, and rules promulgated pursuant to this chapter or the Federal Act, which include:

(A) Minimum standards in the areas of marketing practices;

(B) Network adequacy;

(C) Essential community providers in underserved areas;

(D) Accreditation;

(E) Quality improvement;

(F) Uniform enrollment forms and descriptions of coverage; and

(G) Information on quality measures for health benefit plan performance; and

(7) Be determined by the Authority that making the plan available through the exchanges is in the interest of qualified individuals and qualified employers.

(b) The Authority shall not withhold certification from a health benefit plan:

(1) On the basis that the plan is a fee-for-service plan;

(2) Through the imposition of premium price controls by the Authority; or

(3) On the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances the Authority determines are inappropriate or too costly.

(c) The Authority shall require each health carrier seeking certification of a plan as a qualified health plan to:

(1) Submit a justification for any premium increase before implementation of that increase, and prominently post the information on its publically accessible website;

(2)(A) Make available to the public, in the format described in subparagraph (B) of this paragraph, and submit to the Authority, the Secretary, and the Commissioner, accurate and timely disclosure of the following:

(i) Claims payment policies and practices;

(ii) Periodic financial disclosures;

(iii) Data on enrollment;

(iv) Data on disenrollment;

(v) Data on the number of claims that are denied;

(vi) Data on rating practices;

(vii) Information on cost-sharing and payments with respect to any out-of-network coverage;

(viii) Information on enrollee and participant rights under title I of the Federal Act; and

(ix) Other information as determined appropriate by the Secretary.

(B) The information required in subparagraph (A) of this paragraph shall be provided in plain language, as that term is defined in section 1311(e)(3) (B) of the Federal Act;

(3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider and make this information available to the individual through a website that is publically accessible, and through other means for individuals without access to the Internet; and

(4) Promptly notify affected individuals of price and benefit changes, or other changes in circumstances that could materially impact enrollment or coverage.

(d) The Authority shall not exempt any health carrier seeking certification as a qualified health plan, regardless of the type or size of the health carrier, from District licensure or solvency requirements, and shall apply the criteria of this section in a manner that assures a level playing field between or among health carriers participating in the exchanges.

(e)(1) The provisions of this chapter that are applicable to qualified health plans shall also apply, to the extent relevant, to qualified dental plans except as modified in accordance with the provisions of paragraphs (2), (3) and (4) of this subsection or by regulations adopted by the Authority.

(2) The health carrier shall be licensed to offer dental coverage, but need not be licensed to offer other health benefits.

(3) The plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage and shall include, at a minimum, the essential pediatric dental benefits prescribed by the Secretary pursuant to section 1302(b)(1)(J) of the Federal Act, and such other dental benefits as the Authority or the Secretary may specify by regulation.

(4) Health carriers may jointly offer a comprehensive plan through the exchanges in which the dental benefits are provided by a health carrier through a qualified dental plan and the other benefits are provided by a health carrier through a qualified health plan; provided, that the plans are priced separately and are also made available for purchase separately at the same price.

(f) The Authority shall take the information required by subsection (c)(1) of this section, along with the information and the recommendations provided to the Authority by the Commissioner under section 2794(b) of the PHSA, into consideration when determining whether to allow the health carrier to make plans available through the exchanges.

(Mar. 2, 2012, D.C. Law 19–94, § 10, 59 DCR 213.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 19–94, see notes under § 31–3171.01.

§ 31–3171.10. Conflicts of interest.

(a)(1) A member of the executive board or of the staff of the Authority shall not be employed by, a consultant to, a member of the board of directors of, affiliated with, or otherwise a representative of, a health carrier or other insurer, an agent or broker, a health professional, or a health care facility or health clinic while serving on the board or on the staff of the Authority.

(2) A member of the executive board or of the staff of the Authority shall not be a member, a board member, or an employee of a trade association of health carriers, health facilities, health clinics, or health professionals while serving on the board or on the staff of the Authority.

(3) A member of the executive board or of the staff of the Authority shall not be a health professional unless he or she receives no compensation for rendering services as a health professional and does not have an ownership interest in a professional health care practice.

(b) No member of the executive board or of the staff of the Authority shall, for one year after the end of the member's service on the board or employment by the Authority, accept employment with any health carrier that offers a qualified health benefit plan through the exchanges.

(c) No member of the executive board shall make, participate in making, or in any way attempt to use his or her official position to influence the making of any decision that he or she knows or has reason to know will have a reasonably foreseeable material financial effect, distinguishable from its effect on the public generally, on him or her or a member of his or her immediate family, or on either of the following:

(1) Any source of income, other than gifts and other than loans by a commercial lending institution in the regular course of business on terms available to the public without regard to official status, aggregating $250 or more in value provided to, received by, or promised to the member within 12 months prior to the time when the decision is made.

(2) Any business entity in which the member is a director, officer, partner, trustee, or employee, or holds any position of management.

(Mar. 2, 2012, D.C. Law 19–94, § 11, 59 DCR 213.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 19–94, see notes under § 31–3171.01.

§ 31–3171.11. Open meetings.

The executive and advisory boards shall be subject to subchapter IV of Chapter 5 of Title 2; except, that the executive board may hold closed sessions when considering matters related to litigation, personnel, contracting, or rates.

(Mar. 2, 2012, D.C. Law 19–94, § 12, 59 DCR 213.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 19–94, see notes under § 31–3171.01.

§ 31–3171.12. Limitation of liability.

There shall not be any liability, in a private capacity, on the part of the executive or advisory board members, or any officer, or employee of the executive or advisory board, for or on account of any act performed or obligation entered into in an official capacity when done in good faith, without intent to defraud, and in connection with the administration, management, or conduct of this chapter or affairs related to this chapter.

(Mar. 2, 2012, D.C. Law 19–94, § 13, 59 DCR 213.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 19–94, see notes under § 31–3171.01.

§ 31–3171.13. Relation to other laws.

(a) Nothing in this chapter, and no action taken by the Authority pursuant to this chapter, shall be construed to preempt or supersede the authority of the Commissioner to regulate the business of insurance within the District. Except as expressly provided to the contrary in this chapter, all health carriers offering qualified health plans and qualified dental plans in the District shall comply fully with all applicable health insurance laws of the District and regulations adopted and orders issued by the Commissioner.

(b) Nothing in this chapter, and no action taken by the Authority pursuant to this chapter, shall be construed to preempt or supersede the authority of the Department of Health Care Finance, as the single state agency, to establish policy and enforce the rules and regulations governing Titles XIX and XXI of the Social Security Act and other health-care programs under its jurisdiction.

(Mar. 2, 2012, D.C. Law 19–94, § 14, 59 DCR 213.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 19–94, see notes under § 31–3171.01.

§ 31–3171.14. Powers of the Mayor.

Notwithstanding any other provision of this chapter, all powers and authority vested by this chapter in the Authority shall remain with the Mayor until:

(1) A majority of members of the executive board have been confirmed by the Council; and

(2) The executive board has hired an executive director.

(Mar. 2, 2012, D.C. Law 19–94, § 15, 59 DCR 213.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 19–94, see notes under § 31–3171.01.

§ 31–3171.15. Dissolution of the Authority.

Upon dissolution, liquidation, or other termination of the Authority:

(1) All rights and properties of the Authority shall pass to and be vested in the District, subject to the rights of lien holders and other creditors;

(2) Any net earnings of the Authority, beyond that necessary for retirement of any indebtedness or to implement a public purpose or program of the District authorized under this chapter, shall not inure to the benefit of any person other than the District;

(3) The expenditure of any net earnings shall be restricted to costs related to the direct delivery of health care to residents of the District.

(Mar. 2, 2012, D.C. Law 19–94, § 16, 59 DCR 213.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 19–94, see notes under § 31–3171.01.

§ 31–3171.16. Implementation and reports.

(a) The executive board shall:

(1) Study, in consultation with the advisory boards established under this chapter and with other stakeholders:

(A) The feasibility and desirability of the Authority engaging in:

(i) Selective contracting, either through competitive bidding or a negotiation process similar to that used by large employers, to reduce health care costs and improve quality-of-care by certifying only those health benefit plans that meet certain requirements, such as:

(I) Promoting patient-centered medical homes;

(II) Adopting electronic health records;

(III) Meeting minimum outcome standards;

(IV) Implementing payment reforms to reduce medical errors and preventable hospitalizations;

(V) Reducing disparities;

(VI) Ensuring adequate reimbursements;

(VII) Enrolling high-risk members and underserved populations;

(VIII) Managing chronic conditions and promoting healthy consumer lifestyles;

(IX) Value–based insurance design;

(X) Adhering to transparency guidelines; and

(XI) Uniform price and quality reporting;

(ii) Multistate contracting; and

(iii) Entering into a regional exchange;

(B) The rules under which health benefit plans should be offered inside and outside the exchanges in order to mitigate adverse selection and encourage enrollment in the exchanges, including:

(i) Whether any benefits should be required of qualified health plans beyond those mandated by the Federal Act, and whether any such additional benefits should be required of health benefit plans offered outside the exchanges;

(ii) Whether health carriers offering health benefit plans outside the exchanges should be required to offer either all the same health benefit plans inside the exchanges or, alternatively, at least one health benefit plan inside the exchanges;

(iii) Whether managed care organizations with Health Choice contracts should be required to offer products inside the exchanges;

(iv) Whether health carriers offering health benefit plans inside the exchanges should be required to also participate in the District medical assistance program; and

(v) Which provisions applicable to qualified health plans should be made applicable to qualified dental plans;

(C) The design and operation of the Authority's Navigator program and any other appropriate consumer-assistance mechanisms, including:

(i) How the Navigator program could utilize, interact with, or complement private-sector resources, including insurance producers;

(ii) The infrastructure of the existing private sector health insurance distribution system in the District to determine whether private sector resources may be available and suitable for use by the Authority;

(iii) The effect the exchanges may have on private sector employment in the health insurance distribution system in the District;

(iv) What functions, in addition to those required by the Federal Act, should be performed by Navigators;

(v) What training and expertise should be required of Navigators, and whether different markets and populations require Navigators with different qualifications;

(vi) How Navigators should be retained and compensated, and how disparities between Navigator compensation and the compensation of insurance producers outside the exchanges can be minimized or avoided;

(vii) How to ensure that Navigators provide information in a manner culturally, linguistically, and otherwise appropriate to the needs of the diverse populations served by the Authority, and that Navigators have the capacity to meet these needs; and

(viii) What other means of consumer assistance may be appropriate and feasible, and how they should be designed and implemented;

(D) The design and function of the SHOP Exchange beyond the requirements of the Federal Act, to promote quality, affordability, and portability, including:

(i) Whether it should be a defined contribution/employee choice model or whether employers should choose the qualified health plan to offer their employees;

(ii) Whether the current individual and small group markets should be merged; and

(iii) Whether the SHOP Exchange should be made available to employers with 50 to 100 employees prior to 2016, as authorized by the Federal Act;

(E) How the Authority will ensure financial integrity in compliance with the Federal Act, including:

(i) A recommended plan for the budget of the Authority;

(ii) The user fees, licensing fees, or other assessments that should be imposed by the Authority to fund its operations, including what type of user fee cap or other methodology would be appropriate to ensure that the income of the Authority comports with the expenditures of the Authority; and

(iii) A recommended plan for how to prevent fraud, waste, and abuse; and

(F) How the Authority should conduct its public relations and advertising campaign, including what type of solicitation, if any, of individual consumers or employers, would be desirable and appropriate; and

(2) Report its findings under paragraph (1) of this subsection to the Mayor, Council, and public within 180 days of March 2, 2012.

(b)(1) The executive board shall prepare a plan that identifies how the Authority will be financially self-sustaining by January 1, 2015.

(2) The plan, which shall be certified by an independent actuary as actuarially sound, shall be submitted to the Mayor and Council not later than December 15, 2013.

(Mar. 2, 2012, D.C. Law 19–94, § 17, 59 DCR 213.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 19–94, see notes under § 31–3171.01.

§ 31–3171.17. Rules.

(a) The Authority, pursuant to subchapter I of Chapter 5 of Title 2 shall issue rules to implement the provisions of this chapter.

(b) The Authority shall submit all proposed rules adopted by the Authority to the Council for a 30–day period of review, excluding Saturdays, Sundays, legal holidays, and days of Council recess. If the Council does not approve or disapprove the proposed rules, in whole or in part, by resolution, within this 30–day review period, the proposed rules shall be deemed approved.

(c) Regulations promulgated under this section shall not conflict with or prevent the application of regulations promulgated by the Secretary under the Federal Act.

(Mar. 2, 2012, D.C. Law 19–94, § 18, 59 DCR 213.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 19–94, see notes under § 31–3171.01.

§ 31–3171.18. Applicability.

This chapter shall apply upon the inclusion of its fiscal effect in an approved budget and financial plan.

(Mar. 2, 2012, D.C. Law 19–94, § 19, 59 DCR 213.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 19–94, see notes under § 31–3171.01.

Chapter 33A

Health Insurance Ratemaking.

Section	
31–3311.01.	Ratemaking principles and standards.
31–3311.02.	Aggregate medical loss ratios; dividend; and rating bands.
31–3311.03.	Loss ratio disclosure.
31–3311.04.	Annual rate filing requirement.
31–3311.05.	Commissioner's authority to rescind approved rates.
31–3311.06.	Post–claims underwriting and prior approval for rescission, cancellation, or limitation
31–3311.07.	Public records.
31–3311.08.	Annual report and recommendations.
31–3311.09.	Rules.
31–3311.10.	Application.

§ 31–3311.01. Ratemaking principles and standards.

(a) All insurance premium rates and fees shall be made in accordance with the principles and standards set forth in this section. Uniformity among insurers in matters within the scope of this section shall not be required or prohibited.

(b) Due consideration shall be given to:

(1) Past and prospective loss experience within and, if necessary for actuarial credibility, outside the District;

(2) Conflagration and catastrophe hazards, if any;

(3) Past and prospective expenses, both within and, if necessary for actuarial credibility, outside the District;

(4) Underwriting profits;

(5) Contingencies;

(6) Investment income and reserve for losses as reported by the insurer in the insurer's financial statements;

(7) Dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to policyholders as reported by the insurer in the insurer's financial statements; and

(8) All other relevant factors within and, if necessary for actuarial credibility, outside the District.

(c) Rates or fees shall not be excessive, inadequate, or unfairly discriminatory. In determining whether rates are excessive or unfairly discriminatory, the Commissioner may consider:

(1) Historical and projected loss ratios, as described herein;

(2) Any anticipated change in the number of enrollees if the proposed premium rate is approved;

(3) Changes to cover benefits or health benefit plan design; and

(4) Changes in the insurer's health care cost and quality improvement efforts since the insurer's last rate filing for the same category of health benefit plan.

(d) The systems of expense provisions included in the rates or fees for use by an insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of the insurer or group of insurers with respect to a kind of insurance or with respect to a subdivision or combination of kinds of insurance for which separate expense provisions are applicable.

(e) Except as provided for in subsection (f) of this section, for any rate filing, the carrier shall demonstrate that the product for which the rate is filed has a target medical loss ratio of 70 % or greater for individual and small group policies and 75 % or greater for large group policies.

(f) The Commissioner of the Department of Insurance, Securities, and Banking ("Commissioner"), in his or her discretion, may approve an exemption to the target medical loss ratio set forth in subsection (e) of this section, upon receipt of justification supporting the requested exemption and after a 30–day period of public notice. Justification for a medical loss ratio of less than 70 % for individual and small group policies or less than 75 % for large group policies shall be based upon the following factors:

(1) Product design or cost sharing attributes;

(2) Expected enrollment size;

(3) Length of time in the market;

(4) Claims pool credibility; and

(5) Any other relevant matter.

(Apr. 8, 2011, D.C. Law 18–360, § 102, 58 DCR 896.)

Historical and Statutory Notes

Legislative History of Laws

Law 18–360, the "Reasonable Health Insurance Ratemaking and Health Care Reform Act of 2010", was introduced in Council and assigned Bill No. 18–792, which was referred to the Committee on Public Services and Consumer Affairs. The Bill was adopted on first and second readings on November 9, 2010, and December 7, 2010, respectively. Signed by the Mayor on January 20, 2011, it was assigned Act No. 18–710 and transmitted to both Houses of Congress for its review. D.C. Law 18–360 became effective on April 8, 2011.

§ 31–3311.02. Aggregate medical loss ratios; dividend; and rating bands.

(a) For each calendar year, an insurer shall maintain an aggregate minimum medical loss ratio, as defined by rule, of 80% for individual policies, as defined by rule, 80% for small group policies, as defined by rule, and 85% for large group policies, as defined by rule. The medical loss ratio shall be defined by the Commissioner and shall be determined by rule in a manner and generally consistent with the same standards as the medical loss ratio defined in section 2718(b) of the Public Health Service Act, approved March 23, 2010 (124 Stat. 136; 42 U.S.C. § 300gg–18(b)). No later than May 31st of each year, insurers shall file an annual report with the Commissioner, in a manner and on a form prescribed by Commissioner, indicating the medical loss ratio calculated for all policies and contracts written for the previous calendar year.

(b) All filings of rates and rating schedules shall demonstrate that actual expected claims in relation to premiums comply with the requirements of this act when combined with actual experience to date.

(c) In each case where the insurer fails to substantially comply with the medical loss ratio requirements set forth in subsection (a) of this section, the insurer shall issue a rebate for all policyholders in an amount determined in accordance with section 2718(b)(1)(B) of the Public Health Service Act, approved March 23, 2010 (124 Stat. 136; 42 U.S.C. § 300gg–18(b)(1)(B). The annual report required by this section shall include the insurer's calculation of the rebates and an explanation of the insurer's plan to issue rebates. The instructions and format for calculating and reporting medical loss ratios and issuing rebates shall be prescribed by the Commissioner by rule. The Commissioner shall establish, by rule, procedures for the distribution of a rebate in the event of cancellation or termination by a policyholder.

(d) A plan of individual or small group health insurance rates shall not include a standard rate for any age that is more than 300% of the standard rate for the age with the lowest rate in the same plan and the standard rate for any age shall not be more than 104% of the standard rate for the previous age.

(e) An insurer's failure to comply with the rebate requirements in subsection (c) of this section or rating band requirements set forth in subsection (d) of this section shall constitute an unfair or deceptive act or practice and shall be subject to the penalties in Chapter 22A of this title.

(f) The Commissioner may audit any insurer to assure compliance with this section. Insurers shall retain at their principal place of business information necessary for the Commissioner to perform compliance audits.

(Apr. 8, 2011, D.C. Law 18–360, § 103, 58 DCR 896.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 18–360, see notes under § 31–3311.01.

References in Text

This act, referred to in subsec. (b), is D.C. Law 18–360, the Reasonable Health Insurance Ratemaking and Health Care Reform Act of 2010.

§ 31–3311.03. Loss ratio disclosure.

Policies, certificates, and marketing materials shall prominently display medical loss ratio disclosure, as defined by rule.

(Apr. 8, 2011, D.C. Law 18–360, § 104, 58 DCR 896.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 18–360, see notes under § 31–3311.01.

§ 31–3311.04. Annual rate filing requirement.

All insurers subject to this chapter shall file annually its rates, rating schedule, and supporting documentation, including ratios of incurred losses to earned premiums by policy form or certificate form, for approval by the Commissioner. The supporting documentation shall demonstrate, in accordance with actuarial principles and standards, using reasonable assumptions, that the appropriate medical loss ratio standards can be expected to be met over the entire period for which rates are computed and that insurer is in compliance with the ratemaking principles of this chapter. If the data submitted does not confirm that the insurer has satisfied the requirements of this chapter, the Commissioner shall notify the insurer in writing of the deficiency within 30 business days of the date that the data is submitted. The insurer shall have 30 days after the date of the Commissioner's notice to file amended rates that comply with this chapter. If the insurer fails to file amended rates within the 30–day period, the Commissioner shall order that the insurer's filed rates for the nonconforming policies and certificates be reduced to an amount that would bring the rates into compliance with this chapter. Upon request of the insurer and before any order or notice issued pursuant to this section becomes final, the Commissioner shall hold a hearing upon not less than 10 business days' written notice to the insurer specifying the matters to be considered at the hearing. The insurer's failure to file amended rates within the specified time or the issuance of the Commissioner's order amending the rates shall not preclude the insurer from filing an amendment of its rates at a later time.

(Apr. 8, 2011, D.C. Law 18–360, § 105, 58 DCR 896.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 18–360, see notes under § 31–3311.01.

§ 31–3311.05. Commissioner's authority to rescind approved rates.

(a) The Commissioner may, at any time, require any insurer subject to this chapter to demonstrate that its rates and method for setting rates are in compliance with this chapter, notwithstanding that the filings then in effect had previously been approved. Any rates previously approved by the Commissioner, but subsequently disapproved under this chapter, shall be considered disapproved on a prospective basis only from the date of the notice of disapproval, unless the insurer made a material misrepresentation in its contract form or rate filings, in which case the rates shall be deemed disapproved on a retroactive basis.

(b) If, at any time subsequent to the approval of rates, the Commissioner finds that a filing does not meet the requirements of this act, the Commissioner shall issue an order to the insurer specifying why the filing fails to meet the requirements of this chapter, and, stating when, within a reasonable period thereafter, the filing shall be no longer effective. The order shall not affect any subscriber contract, group certificate, or other contract made or issued prior to the expiration of the period set forth in the order. The Commissioner may, prior to issuing the order and if requested by the insurer, hold a hearing upon not less than 10 business days' written notice to the insurer specifying the matters to be considered at the hearing.

(c) For violations of this chapter, the Commissioner may order any relief which is appropriate, including disapproving a rate and awarding interest.

(Apr. 8, 2011, D.C. Law 18–360, § 106, 58 DCR 896.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 18–360, see notes under § 31–3311.01.

References in Text

This act, referred to in subsec. (b), is D.C. Law 18–360, the Reasonable Health Insurance Rate-making and Health Care Reform Act of 2010.

§ 31–3311.06. Post–claims underwriting and prior approval for rescission, cancellation, or limitation

(a) An insurer shall not rescind an enrollee's plan or coverage once the enrollee is covered under the plan or coverage involved; provided, that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. The plan or coverage shall not be cancelled without prior notice to the Commissioner as required by subsection (b) of this section and prior notice to the consumer and an opportunity to appeal as required by the Patient Protection and Affordable Care Act, approved March 23, 2010 (124 Stat. 109; scattered sections of the United States Code).

(b) A health carrier shall provide at least 30 days advance written notice to each plan enrollee, or for individual health insurance coverage, primary subscriber, who would be affected by the proposed rescission of coverage before coverage under the plan may be rescinded in accordance with subsection (a) of this section regardless of, in the case of group or only to an individual within the group. The notice shall explain the reason for the rescission, procedures of appealing, and how to contact the Health Care Ombudsman and the Department of Insurance, Securities, and Banking for further information.

(c) Prior to rescinding the enrollee's plan or coverage, the insurer shall provide to the Commissioner documentation to support the rescission and the Commissioner shall have 5 business days following receipt of the proposed rescission and supporting documentation to review the documentation to determine if the insurer is complying with the requirements of subsection (a) of this section. The insurer may rescind the plan or coverage after the end of the 5–day period of review unless the Commissioner objects or disapproves the proposed rescission within the 5–day period.

(Apr. 8, 2011, D.C. Law 18–360, § 107, 58 DCR 896.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 18–360, see notes under § 31–3311.01.

§ 31–3311.07. Public records.

The Commissioner shall, as soon as practicable, make all rate filings, including all supporting documentation, amended filings, and reports filed pursuant to this chapter, available for public inspection either at the Department of Insurance, Securities, and Banking or on its website.

(Apr. 8, 2011, D.C. Law 18–360, § 108, 58 DCR 896.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 18–360, see notes under § 31–3311.01.

§ 31–3311.08. Annual report and recommendations.

On June 1, 2011, and every year thereafter, the Commissioner shall report to the Council any significant National Association of Insurance Commissioners adoptions related to health care reform, including medical loss ratios and loss ratio disclosure, and any recommendations if the District law differs.

(Apr. 8, 2011, D.C. Law 18–360, § 109, 58 DCR 896.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 18–360, see notes under § 31–3311.01.

§ 31–3311.09. Rules.

The Mayor, pursuant to subchapter I of Chapter 5 of Title 2, shall issue rules to implement the provisions of this chapter.

(Apr. 8, 2011, D.C. Law 18–360, § 110, 58 DCR 896.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 18–360, see notes under § 31–3311.01.

§ 31–3311.10. Application.

This chapter shall apply to policies and certificates of insurance that are health benefit plans as defined under § 31–3271(4) that are issued 90 days after April 8, 2011. This chapter shall not apply to short-term limited duration health benefit plans.

(Apr. 8, 2011, D.C. Law 18–360, § 111, 58 DCR 896.)

Historical and Statutory Notes

Legislative History of Laws

For history of Law 18–360, see notes under § 31–3311.01.

Chapter 34

Health Maintenance Organizations.

Section
31–3401. Definitions.
31–3403.01. Premium tax.
31–3408.01. Compliance with other laws.
31–3415. Filing requirements for rating information.

§ 31–3401. Definitions.

Historical and Statutory Notes

Temporary Addition of Section

Section 101 to 106 of D.C. Law 18–271 added sections to read as follows:

"Sec. 101. Establishment of the DC High Risk Pool Program.

"(a) There is established the DC High Risk Pool Program ('Program'), which shall provide affordable health insurance benefits to eligible individuals.

"(b) The Program shall be:

"(1) Administered by the Department of Health Care Finance, established by the Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17–109; D.C. Official Code § 7–771.01 *et seq.*);

"(2) Funded through federal funds made available through the temporary high risk pool program, established by the Patient Protection and Affordable Care Act, approved March 23, 2010 (124 Stat. 119; 42 U.S.C. § 18001) ('federal act'), and administered by the U.S. Department of Health and Human Services;

"(3) Subject to the availability of funding; and

"(4) Expire on December 31, 2013; provided, that federal requirements or contractual obligations between the District and the U.S. Department of Health and Human Services do not necessitate a different date.

"(c) Nothing in this section shall be construed to create or constitute an entitlement to health insurance or to health or medical benefits.

"Sec. 102. Program eligibility.

"An individual shall be eligible for the Program if the individual:

"(1) Is a District resident;

"(2) Is a United States citizen, or lawfully in the country;

"(3) Has not had creditable health coverage for the 6 months prior to applying for the Program;

"(4) Has one or more pre-existing conditions that have resulted in the inability to obtain commercial insurance coverage on the individual market; and

"(5) Is not eligible for public health-insurance benefits.

"Sec. 103. Program benefits.

"The Program shall provide comprehensive coverage for services that meet the requirements of the temporary high risk pool program, established by the federal act.

"Sec. 104. Affordability of coverage.

"Under the Program:

"(1) The premium levels charged to enrollees shall be no greater than 100% of the standard risk rate for each age group, with a variability no greater than 4–to–1 between any 2 age groups;

"(2) The out-of-pocket limit of coverage for cost-sharing for the required benefits shall not be greater than the applicable amount described in section 223(c)(2) of the Internal Revenue Code of 1986, approved December 8, 2003 (117 Stat. 2469; 26 U.S.C. § 223(c)(2)), for the year involved; and

"(3) There shall not be any annual or lifetime dollar limits on any service, including prescription drugs.

"Sec. 105. Program implementation.

"To meet the deadline set by the U.S. Department of Health and Human Services, the Mayor is authorized to enter into a contract with a qualified insurer or hospital and medical services corporation licensed in the District.

"Sec. 106. Rules.

"The Mayor, pursuant to Title I of the District of Columbia Administrative Procedure Act, approved October 21, 1968 (82 Stat. 1204; D.C. Official Code § 2–501 *et seq.*), shall issue rules to implement the provisions of this title."

Section 302(b) of D.C. Law 18–271 provides that the act shall expire after 225 days of its having taken effect.

Emergency Act Amendments

For temporary (90 day) additions, see §§ 101 to 106 of DC High Risk Pool Program Establishment Emergency Act of 2010 (D.C. Act 18–522, August 3, 2010, 57 DCR 8001).

§ 31–3403.01. Premium tax.

(a) Effective January 1, 2009, all health maintenance organizations shall pay to the District of Columbia, for each calendar year, a sum of money as taxes equal to 2% of their policy and

membership fees and net premium receipts or consideration received in such calendar year, excluding those fees, receipts, or consideration received pursuant to any federal employee health-benefit program or Medicare, on all policies or contracts in the District of Columbia. The premium tax shall be in lieu of all other taxes except:

(1) Taxes upon real estate; and

(2) Fees and charges provided for pursuant to this chapter.

(b) The certificate of authority of any health maintenance organization may be revoked for failure to pay the required premium tax.

(c) All revenues generated pursuant to this section shall be collected in a manner prescribed by the Mayor.

(d) Any revenues generated from this section arising from contracts for services under the District's Medicaid program, DC HealthCare Alliance program, or Healthy DC program shall be deposited in the Healthy DC and Health Care Expansion Fund, established by § 31–3514.02.

(e) Of all other revenues generated pursuant to this section, 75% shall be deposited in the Healthy DC and Health Care Expansion Fund and 25% shall be deposited in the General Fund of the District of Columbia.

(f) For the purposes of this section, the term, "health maintenance organization" shall include prepaid health plans.

(Apr. 9, 1997, D.C. Law 11–235, § 4a, as added Aug. 16, 2008, D.C. Law 17–219, § 5054, 55 DCR 7598; Feb. 4, 2010, D.C. Law 18–104, § 4(b), 56 DCR 9182; Sept. 24, 2010, D.C. Law 18–223, § 5022, 57 DCR 6242.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 18–104, in subsec. (a–1), substituted "District Medicaid program, the Healthy DC Program," for "District Medicaid program,".

D.C. Law 18–223, in subsec. (a), deleted "the District Medicaid Program, the Healthy DC Program, the DC HealthCare Alliance," following "pursuant to"; rewrote subsec. (d); and added subsecs. (e) and (f). Prior to amendment, subsec. (d) read as follows:

"(d) Seventy–five percent of the revenue generated pursuant to this section shall be deposited in the Healthy DC Fund, established by § 31–3514.02. The remaining 25% shall be deposited in the General Fund of the District of Columbia."

Temporary Amendments of Section

Section 4(b) of D.C. Law 18–134 substituted "District Medicaid program, the Healthy DC Program," for "District Medicaid program,".

Section 6(b) of D.C. Law 18–134 provides that the act shall expire after 225 days of its having taken effect.

Section 2 of D.C. Law 18–205, in subsec. (a), deleted "the District Medicaid Program, the Healthy DC Program, the DC HealthCare Alliance,"; rewrote subsec. (d) to read as follows:

"(d) Any revenues generated from this section arising from contracts for services under the District's Medicaid program, DC HealthCare Alliance program, or Healthy DC program shall be deposited in the Healthy DC and Health Care Expansion Fund, established by section 15b of the Hospital and Medical Services Corporation Regulatory Act of 1996, effective March 2, 2007 (D.C. Law 16–192; D.C. Official Code § 31–3514.02).".

; and added subsecs. (e) and (f) to read as follows:

"(e) Of all other revenues generated pursuant to this section, 75% shall be deposited in the Healthy DC and Health Care Expansion Fund and 25% shall be deposited in the General Fund of the District of Columbia.

"(f) For the purposes of this section, the term, "health maintenance organization" shall include prepaid health plans.".

Section 7(b) of D.C. Law 18–205 provides that the act shall expire after 225 days of its having taken effect.

Emergency Act Amendments

For temporary (90 day) amendment of section, see § 4(b) of Hospital and Medical Services Corporation Regulatory Emergency Amendment Act of 2009 (D.C. Act 18–277, January 11, 2010, 57 DCR 935).

For temporary (90 day) amendment of section, see § 2 of Medicaid Resource Maximization Emergency Amendment Act of 2010 (D.C. Act 18–390, May 7, 2010, 57 DCR 4339).

For temporary (90 day) amendment of section, see § 5022 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–104, see notes following § 31–205.

For Law 18–223, see notes following § 31–101.

Miscellaneous Notes

Short title: Section 5021 of D.C. Law 18–223 provided that subtitle C of title IV of the act may

be cited as the "Medicaid Resource Maximization Amendment Act of 2010".

§ 31–3408.01. Compliance with other laws.

Health maintenance organizations shall comply with the following laws:

(1) Chapter 3 of this title;

(2) Chapter 19 of this title;

(3) Chapter 14 of this title;

(4) Subchapter I of Chapter 7 of this title;

(5) Chapter 21 of this title; and

(6) The Reasonable Health Insurance Ratemaking Reform Act of 2010 [Chapters 30A, 31C, and 33A of this title].

(Apr. 9, 1997, D.C. Law 11–235, § 9a, as added Mar. 27, 2003, D.C. Law 14–252, § 2(d), 50 DCR 225; Apr. 8, 2011, D.C. Law 18–360, § 502(a), 58 DCR 896.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 18–360 deleted "and" from the end of par. (4), substituted "; and" for a period the end of par. (5), and added par. (6).

Legislative History of Laws

For history of Law 18–360, see notes under § 31–2231.11.

§ 31–3415. Filing requirements for rating information.

(a) No fees may be used until either a schedule of enrollment fees or methodology for determining enrollment fees dues has been filed with and approved by the Commissioner.

(b) Either a specific schedule of fees, or a methodology for determining fees, shall be established in accordance with actuarial principles for various categories of enrollees, provided that the enrollment fees applicable to an enrollee shall not be individually determined based on the status of an enrollee's health. However, the fees shall not be excessive, inadequate, or unfairly discriminatory. A statement by a qualified actuary or other qualified person acceptable to the Commissioner as to the appropriateness of the use of the methodology, based on reasonable assumptions, shall accompany the filing along with adequate supporting information. A health maintenance organization filing a schedule of enrollment fees or methodology for determining enrollment fees pursuant to this section shall also comply with the Reasonable Health Insurance Ratemaking Reform Act of 2010 [Chapters 30A, 31C, and 33A of this title].

(c) The Commissioner shall approve the schedule of enrollment fees dues or methodology for determining enrollment fees if the requirements of subsection (b) of this section are met. If the Commissioner disapproves the filing, the Commissioner shall notify the health maintenance organization. In the notice, the Commissioner shall specify the reasons for disapproval. A hearing shall be held within 30 days after a request in writing by the person filing. If the Commissioner does not take action on the schedule or methodology within 30 days of the filing, it shall be deemed approved.

(Apr. 9, 1997, D.C. Law 11–235, § 16, 44 DCR 818; Apr. 8, 2011, D.C. Law 18–360, § 502(b), 58 DCR 896.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 18–360, in subsec. (b), added the fourth sentence.

Emergency Act Amendments

For temporary (90 day) amendment of section, see § 2 of Reasonable Health Insurance Premium Increase Emergency Amendment Act of 2010 (D.C. Act 18–328, March 18, 2010, 57 DCR 2546).

Legislative History of Laws

For history of Law 18–360, see notes under § 31–2231.11.

Chapter 35

Hospital and Medical Services Corporations Regulation.

Section	
31–3501.	Definitions.
31–3503.	Applicability of other provisions.
31–3505.	Requirements for issuance of certificate of authority.
31–3506.	Surplus requirements.
31–3506.01.	Compliance and implementation of community health reinvestment obligations.
31–3508.	Filing of subscriber contract forms and rates.
31–3514.	Open enrollment.
31–3514.02.	Establishment of Healthy DC and Health Care Expansion Fund.

§ 31–3501. Definitions.

For the purposes of this chapter, the term:

(1) "Commissioner" means the Commissioner of the Department of Insurance, Securities, and Banking.

(1A) "Community health reinvestment" means expenditures that promote and safeguard the public health or that benefit current or future subscribers, including premium rate reductions.

(1B) "Contractholder" means a person entering into a subscriber contract with a corporation.

(2) "Corporation" means a nonstock, nonprofit corporation which is subject to regulation and licensing under this chapter and which offers subscriber contracts as part of a hospital service plan, a medical service plan, or both.

(3) "Domestic corporation" means a corporation organized under the laws of the District, or formed or organized under an act of Congress.

(3A) "Healthy DC and Health Care Expansion Fund" means the Healthy DC and Health Care Expansion Fund established by § 31–3514.02.

(4) "Hospital service plan" means a plan for providing hospital and related services by hospitals and others which entitles a subscriber to certain hospital and related services, or to benefits and indemnification for such services.

(5) "Mayor" means the Mayor of the District of Columbia or the Mayor's designated agent.

(6) "Medical service plan" means a plan for providing medical services and related services by physicians and others which entitles a subscriber to certain medical and related services, or to benefits and indemnification for such services.

(7) "Plan" means a hospital service plan, a medical service plan, or a combination of the two.

(7A) Public-private partnership" means a mutually acceptable written agreement between the Mayor and a hospital and medical services corporation that is certified by the Commissioner upon the execution and delivery of the agreement by the parties and which agreement:

(A) Shall include the following provisions:

(i) A $5 million annual payment to the Healthy DC Fund (or appropriate successor fund) by the hospital and medical services corporation to be used for subsidies that expand health insurance coverage for low-income District residents;

(ii) A targeted city-wide health care initiative aimed at improving nutrition and increasing physical fitness among the District's senior citizens, or another comparable health promotion program;

(iii) A term not to exceed 5 years, subject to extension upon the mutual written agreement of the parties;

(iv)(I)(aa) The maintenance and support of the existing District open enrollment program as it operated prior to the enactment of the Medical Insurance Empowerment Amendment Act of 2008, effective March 25, 2009 (D.C. Law 17–369; 56 DCR

1346)("open enrollment program"), which program has an estimated average premium of $357 per member per month, and the enhancement of the open enrollment program by offering a new health maintenance organization product that includes comprehensive benefits with an average initial premium currently estimated at about $300 per member per month, which average may vary based upon age and family status, and subject to other reasonable adjustments, but with no adjustments for gender or pre-existing conditions.

(bb) The annual premium rate of the existing open enrollment program shall not exceed 125% of the comparable medically underwritten product and shall be determined once every 12 months. The benefit package shall include, at a minimum, primary care services, specialist services, temporomandibular joint problems chiropractic services, mental health and addiction treatment, organ transplantation, treatment for morbid obesity, open heart surgery, and pharmaccutical benefits.

(cc) The medical loss ratio to be utilized in rate filings and determinations shall not exceed 150%;

(II) Under the open enrollment program pursuant to sub-sub-subparagraph (I) of this sub–subparagraph:

(aa) Current members shall be permitted to maintain the option to continue their current open enrollment program coverage or opt for the new health maintenance organization product;

(bb) New open enrollment members shall only be offered the new health maintenance organization product; and

(cc) Total enrollment under subparagraph (A)(iv)(I) of this paragraph shall be capped at 2,500;

(v) Participation in the open enrollment program (including the health maintenance organization product) may be limited to District residents, which shall be subject to periodic confirmation; and

(vi)(I) A corporation shall prominently advertise the availability of the new open enrollment health maintenance organization product continuously on the Internet and at least quarterly in a newspaper of general circulation throughout the District.

(II) The content and format of the advertising shall be filed with the Commissioner no less than 30 days before its appearance in a newspaper or on the Internet;

(B) May include the following provisions:

(i) Authority for the Commissioner to grant a hospital and medical services corporation reasonable relief from the requirements of the agreement, such as if federal or state health care reforms make the requirements unnecessary or redundant or if the corporation does not meet a financial performance or similar test as specified in the agreement; provided, that any relief granted shall not affect the certification of the agreement by the Commissioner or the status of the agreement as a public-private partnership for all purposes under this chapter; and

(ii) Reasonable expiration and termination provisions; and

(C) Shall be effective upon the certification of the Commissioner.

(7B) "RS Fund" means the rate stabilization fund established by § 31–3514(j).

(8) "Subscriber" means any person entitled to benefits under the terms and conditions of a subscriber contract.

(9) "Subscriber contract" means a written group or individual contract which is issued to a contractholder by a corporation which provides for subscriber participation in a hospital service plan, a medical service plan, or a combination of the two.

(10) "Subsidiary" means an affiliate controlled by a corporation directly or indirectly through 1 or more intermediaries.

(11) "Surplus" means the amount by which all admitted assets of the corporation exceed its liabilities, inclusive of the reserves required pursuant to § 31–3509.

(Apr. 9, 1997, D.C. Law 11–245, § 2, 44 DCR 1158; Mar. 2, 2007, D.C. Law 16–192, § 5012(a), 53 DCR 6899; Mar. 25, 2009, D.C. Law 17–369, § 2(a), 56 DCR 1346; Feb. 4, 2010, D.C. Law 18–104, § 2(a), 56 DCR 9182; Sept. 24, 2010, D.C. Law 18–223, § 5023(a), 57 DCR 6242.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 18–104 redesignated former par. (7A) as par. (7B); and added par. (7A).

D.C. Law 18–223, in par. (3A), substituted "Healthy DC and Health Care Expansion Fund" for "Healthy DC Fund" both times it appears.

Temporary Amendments of Section

Section 2(a) of D.C. Law 18–134 designated par. (7A) as par. (7B); and added par. (7A) to read as follows:

"'(7A) Public-private partnership' means a mutually acceptable written agreement between the Mayor and a hospital and medical services corporation that is certified by the Commissioner upon the execution and delivery of the agreement by the parties and which agreement:

"(A) Shall include the following provisions:

"(i) A $5 million annual payment to the Healthy DC Fund (or appropriate successor fund) by the hospital and medical services corporation to be used for subsidies that expand health insurance coverage for low-income District residents;

"(ii) A targeted city-wide health care initiative aimed at improving nutrition and increasing physical fitness among the District's senior citizens, or another comparable health promotion program;

"(iii) A term not to exceed 5 years, subject to extension upon the mutual written agreement of the parties;

"(iv)(I)(aa) The maintenance and support of the existing District open enrollment program as it operated prior to the enactment of the Medical Insurance Empowerment Amendment Act of 2008, effective March 25, 2009 (D.C. Law 17–369; 56 DCR 1346)('open enrollment program'), which program has an estimated average premium of $357 per member per month, and the enhancement of the open enrollment program by offering a new health maintenance organization product that includes comprehensive benefits with an average initial premium currently estimated at about $300 per member per month, which average may vary based upon age and family status, and subject to other reasonable adjustments, but with no adjustments for gender or pre-existing conditions.

"(bb) The annual premium rate of the existing open enrollment program shall not exceed 125% of the comparable medically underwritten product and shall be determined once every 12 months. The benefit package of the health maintenance organization product shall include, at a minimum, primary care services, specialist services, temporomandibular joint problems chiropractic services, mental health and addiction treatment, organ transplantation, treatment for morbid obesity, open heart surgery, and pharmaceutical benefits.

"(cc) The medical loss ratio of the health maintenance organization product to be utilized in rate filings and determinations shall not exceed 150%;

"(II) Under the open enrollment program pursuant to sub-sub-subparagraph (I) of this sub-subparagraph:

"(aa) Current members shall be permitted to maintain the option to continue their current open enrollment program coverage or opt for the new health maintenance organization product;

"(bb) New open enrollment members shall only be offered the new health maintenance organization product; and

"(cc) Total enrollment under subparagraph A)(iv)(I) of this paragraph shall be capped at 2,500;

"(v) Participation in the open enrollment program (including the health maintenance organization product) may be limited to District residents, which shall be subject to periodic confirmation; and

"(vi)(I) A corporation shall prominently advertise the availability of the new open enrollment health maintenance organization product continuously on the Internet and at least quarterly in a newspaper of general circulation throughout the District.

"(II) The content and format of the advertising shall be filed with the Commissioner no less than 30 days before its appearance in a newspaper or on the Internet;

"(B) May include the following provisions:

"(i) Authority for the Commissioner to grant a hospital and medical services corporation reasonable relief from the requirements of the agreement, such as if federal or state health care reforms make the requirements unnecessary or redundant or if the corporation does not meet a financial performance or similar test as specified in the agreement; provided, that any relief granted shall not affect the certification of the agreement by the Commissioner or the status of the agreement as a public-private partnership for all purposes under this act; and

"(ii) Reasonable expiration and termination provisions; and

"(C) Shall be effective upon the certification of the Commissioner.".

Section 6(b) of D.C. Law 18–134 provides that the act shall expire after 225 days of its having taken effect.

Section 3(a) of D.C. Law 18–205, in par. (3A), substituted "Healthy DC and Health Care Expansion Fund" for "Healthy DC Fund" both times it appears.

Section 7(b) of D.C. Law 18–205 provides that the act shall expire after 225 days of its having taken effect.

Section 201(a) of D.C. Law 18–271 amended subsec. (7A)(A)(v) to read as follows:

"(v) Participation in the open enrollment program (including the health maintenance organization product) may be limited to District residents who are ineligible for the DC High Risk Pool Program, as defined in the DC High Risk Pool Program Establishment Temporary Act of 2010, passed on 2nd reading on September 21, 2010 (Enrolled version of Bill 18–939). Participant eli-

gibility shall be subject to periodic confirmation; and".

Section 302(b) of D.C. Law 18–271 provides that the act shall expire after 225 days of its having taken effect.

Emergency Act Amendments

For temporary (90 day) amendment of section, see § 2(a) of Hospital and Medical Services Corporation Regulatory Emergency Amendment Act of 2009 (D.C. Act 18–277, January 11, 2010, 57 DCR 935).

For temporary (90 day) amendment of section, see § 3(a) of Medicaid Resource Maximization Emergency Amendment Act of 2010 (D.C. Act 18–390, May 7, 2010, 57 DCR 4339).

For temporary (90 day) amendment of section, see § 201(a) of DC High Risk Pool Program Establishment Emergency Act of 2010 (D.C. Act 18–522, August 3, 2010, 57 DCR 8001).

For temporary (90 day) amendment of section, see § 5023(a) of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–104, see notes following § 31–205.

For Law 18–223, see notes following § 31–101.

§ 31–3503. Applicability of other provisions.

(a) A corporation governed by this chapter shall also be subject to the following other provisions of District of Columbia insurance law, including any amendments or replacements thereof hereafter enacted:

(1) Sections 31–201, 31–202, and 31–206, referring to general provisions of insurance regulation;

(2) Section 31–207, referring to general provisions of insurance regulation;

(3) Sections 31–5203 and 31–5204, referring to delivery (with each policy issued) of a copy of the insured's application, and to the principal office, books, and records of insurance companies;

(4) Chapter 16 of this title, referring to prohibition against discrimination in the provision of insurance on the basis of an AIDS test;

(5) Chapter 42 of this title, referring to the applicability of, and definitions in, the Life Insurance Act;

(6) Sections 31–4301, 31–4302, 31–4303, 31–4305, 31–4308, 31–4309, 31–4310(b), 31–4311 through 31–4317, 31–4322 and 31–4324 through 31–4332, governing, in part, fees chargeable to, certificates of authority for, publication of false statements by, and licensing of agents acting for life insurance companies;

(7) Sections 31–4713 through 31–4715, 31–4718, and 31–4724 through 31–4730, referring, in part, to the prohibitions against discrimination, securities, operations, and policy provisions restricting access to optometrists and psychologists by life insurance companies;

(8) Sections 31–4401 through 31–4404, 31–4406, 31–4407, 31–4409, 31–4427, 31–4429, 31–4430, 31–4435, 31–4439, 31–4440, and 31–4443 through 31–4452, referring, in part, to articles of incorporation, election of officers, permissible investments, bookkeeping, and consolidation/merger of domestic life insurance companies;

(9) Chapter 46 of this title, governing penalties for violations and severability with respect to the provisions cited in paragraphs 5 through 8 of this subsection;

(10) Chapter 38 of this title, requiring that certain individual and group health insurance policies cover a newborn child from the moment of birth;

(11) Chapter 54 of this title, creating the District of Columbia Life and Health Insurance Guarantee Association and authorizing it to assume, guarantee, and reinsure any policy issued by a member insurer which becomes potentially unable to fulfill its contractual obligations;

(12) Chapter 31 of this title, requiring certain group and individual health insurance policies to provide coverage for the medical and psychological treatment of alcohol abuse, drug abuse, and mental illness;

(13) Chapter 29 of this title, requiring a group or individual health insurance policy issued more than 120 days after March 7, 1991, to cover certain preventive cancer screens for women;

(14) Chapter 37 of this title, authorizing the Mayor to issue regulations establishing specific standards for Medicare supplement insurance policies;

(15) Chapter 12 of this title, establishing the Insurance Regulatory Trust Fund and requiring each insurer doing business in the District to deposit in the Fund a percentage amount to be used to defray expenses of the Insurance Administration;

(16) Chapter 13 of this title, authorizing and regulating delinquency proceedings by the Commissioner of Insurance and Securities in the Superior Court of the District of Columbia against certain insurers;

(17) Chapter 15 of this title, establishing licensing and other requirements for managing general agents of certain insurers;

(18) Chapter 18 of this title, establishing licensing and other requirements for the assumed reinsurance business;

(19) Chapter 3 of this title, requiring insurers to file with the Mayor an accountant-prepared annual audit and other reports;

(20) Chapter 5 of this title, governing the circumstances under which a domestic insurer may obtain a credit for reinsurance ceded to another insurer;

(21) Chapter 19 of this title, governing an insurer's filing with the Mayor and the National Association of Insurance Commissioners ("NAIC") of an annual financial statement;

(22) Chapter 21 of this title, establishing standards for determining whether the continued operation of any insurer transacting business in the District might be hazardous to creditors, the general public, or policyholders, and authorizing the Mayor to order certain corrective actions after making such a determination;

(23) Chapter 14 of this title, governing examinations by the Mayor or any person subject to the District's insurance laws;

(24) Chapter 7 of this title, governing certain acquisition, investment, security issuance, and other activities in the insurance industry, requiring the registration of insurers that are part of an insurance holding company system, regulating transactions within such a system, regulating the management of domestic insurers in such a system, and authorizing the Mayor to conduct examinations of insurers that are part of such a system;

(25) Chapter 49 of this title, requiring the submission to the Mayor of an annual opinion by a qualified actuary;

(26) Chapter 26 of Title 47, requiring an annual license or certificate of authority from the Commissioner of Insurance and Securities for each insurer doing business in the District, requiring the filing of an annual statement by each such insurer, and imposing a tax on each such insurer's at-risk business in the District;

(27) Chapter 20 of this title, requiring insurers to file with the Mayor annual risk-based capital reports; and

(28) The Reasonable Health Insurance Ratemaking Reform Act of 2010 [Chapters 30A, 31C, and 33A of this title].

(b) Reference in the provisions cited in subsection (a) of this section to "insurers", "companies", or similar terms shall be deemed to include reference to a corporation governed by this chapter.

(Apr. 9, 1997, D.C. Law 11–245, § 4, 44 DCR 1158; Mar. 25, 2009, D.C. Law 17–369, § 2(b), 56 DCR 1346; Apr. 8, 2011, D.C. Law 18–360, § 503(a), 58 DCR 896.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 18–360 deleted "and" from the end of par. (26); substituted "; and" for a period the end of par. (27); and added par. (28).

Legislative History of Laws

For history of Law 18–360, see notes under § 31–2231.11.

§ 31–3505. Requirements for issuance of certificate of authority.

The Mayor shall issue a certificate of authority to each applicant upon the payment of the $200 fee provided for in § 31–3504(b), and upon being satisfied that:

(a) The applicant has been organized bona fide for the purpose of establishing, maintaining, and operating a hospital service plan, a medical service plan, or combination of the two;

(b) Each contract executed, or proposed to be executed, by the applicant and any hospital, physician, or other medical provider for the furnishing of hospital or medical services to

subscribers obligates, or will when executed obligate, each hospital, physician, or other similar service provider which is a party thereto to render the service to which each subscriber may be entitled under the terms and conditions of the various subscriber contracts issued, or proposed to be issued, by the applicant;

(c) Each subscriber contract issued, or proposed to be issued, in the District of Columbia is in a form approved by the Mayor, and that the rate charged, or proposed to be charged, for each form of such contract is approved by the Mayor as not being excessive, inadequate, or unfairly discriminatory in relation to the services and benefits offered; provided, that rates for experience rated groups need not, in accordance with § 31–3508(c), be filed with the Mayor;

(d) The applicant has a surplus of an amount equal to or greater than that required under § 31–3506, or the amount determined to be necessary pursuant to application of any risk-based capital regulations for hospital and medical services corporations promulgated by the Mayor; and

(e) The applicant has:

(1) Made provision for compliance with the open enrollment requirements of § 31–3514, including the providing of other public services in the District; or

(2) Has entered into a public-private partnership.

(Apr. 9, 1997, D.C. Law 11–245, § 6, 44 DCR 1158; Feb. 4, 2010, D.C. Law 18–104, § 2(b), 56 DCR 9182.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 18–104 rewrote subsec. (e), which had read as follows:

"(e) The applicant has made provision for compliance with the open enrollment requirements of § 31–3514, including the providing of other public services in the District of Columbia as required in § 31–3514."

Temporary Amendments of Section

Section 2(b) of D.C. Law 18–134 amended subsec. (e) to read as follows:

"(e) The applicant has:

"(1) Made provision for compliance with the open enrollment requirements of section 15, including the providing of other public services in the District; or

"(2) Has entered into a public-private partnership.".

Section 6(b) of D.C. Law 18–134 provides that the act shall expire after 225 days of its having taken effect.

Emergency Act Amendments

For temporary (90 day) amendment of section, see § 2(b) of Hospital and Medical Services Corporation Regulatory Emergency Amendment Act of 2009 (D.C. Act 18–277, January 11, 2010, 57 DCR 935).

Legislative History of Laws

For Law 18–104, see notes following § 31–205.

§ 31–3506. Surplus requirements.

(a) At the time of issuance of a certificate of authority under this chapter and at all times thereafter until risk-based capital regulations for hospital and medical services corporations are promulgated, a corporation must possess surplus in an amount which is the greater of $5,000,000 or 8.0% of the total amount of premiums for insured risk received by the corporation in the preceding calendar year. The total amount of premiums for insured risk shall not include premiums collected for federal health benefit programs that have a separate reserve fund held by the federal government.

(b) The surplus requirement of 8.0% shall be phased-in following April 9, 1997 as follows:

(1) Year one — 40% of the surplus requirement in subsection (a) of this section;

(2) Year two — 60% of the surplus requirement in subsection (a) of this section;

(3) Year three — 80% of the surplus requirement in subsection (a) of this section; and

(4) Year four — 100% of the surplus requirement in subsection (a) of this section.

(c) The Mayor shall have the authority to require the differentiation of the corporation's activities into risk and nonrisk business for the purpose of determining the corporation's income that is derived from premiums for insured risk and from other sources.

(d) Notwithstanding the provisions of subsection (a) of this section, at the time of issuance of a certificate of authority under this chapter and at all times thereafter, a corporation shall

be subject to the provisions of any risk-based capital regulations for hospital and medical services corporations promulgated by the Mayor, and must maintain at all times such surplus as is determined to be necessary under those regulations.

(e) The Commissioner may, on an annual basis, and shall, on a basis no less frequently than every 3 years, review the portion of the surplus of the corporation that is attributable to the District and may issue a determination as to whether the surplus is excessive. Any such review shall be undertaken in coordination with the other jurisdictions in which the corporation conducts business. The surplus may be considered excessive only if:

(1) The surplus is greater than the appropriate risk-based capital requirements as determined by the Commissioner for the immediately preceding calendar year; and

(2) After a hearing, the Commissioner determines that the surplus is unreasonably large and inconsistent with the corporation's obligation under § 31–3505(a).

(f) In determining whether the surplus of the corporation that is attributable to the District is excessive, the Commissioner shall take into account all of the corporation's financial obligations arising in connection with the conduct of the corporation's insurance business, including premium tax paid and the corporation's contribution to the open enrollment program required by § 31–3514 and payments and expenditures pursuant to a public-private partnership.

(g)(1) If the Commissioner determines that the surplus of the corporation is excessive, the Commissioner shall order the corporation to submit a plan for dedication of the excess to community health reinvestment in a fair and equitable manner.

(2) A plan submitted pursuant to paragraph (1) of this subsection may consist entirely of expenditures for the benefit of current subscribers of the corporation.

(h) When determining what surplus is attributable to the District and whether the surplus is excessive, the Commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals, the cost of which shall be borne by the corporation.

(i) If the Commissioner determines that the corporation failed to submit a plan as ordered under subsection (g) of this section within a reasonable period or failed to execute within a reasonable period a plan already submitted under subsection (g) of this section, the Commissioner shall deny for 12 months all premium rate increases for subscriber policies written in the District sought by the corporation pursuant to § 31–3508 and may issue such orders as are necessary to enforce the purposes of this chapter.

(j) The existence of a public-private partnership shall not preclude the Commissioner's surplus evaluation of the corporation or diminish the Commissioner's authority to issue directives to the corporation pursuant to the evaluation.

(Apr. 9, 1997, D.C. Law 11–245, § 7, 44 DCR 1158; Mar. 25, 2009, D.C. Law 17–369, § 2(d), 56 DCR 1346; Feb. 4, 2010, D.C. Law 18–104, § 2(c), 56 DCR 9182.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 18–104, in subsec. (e), substituted "The Commissioner may, on an annual basis, and shall, on a basis no less frequently than every 3 years, review the portion of the surplus of the corporation that is attributable to the District and may issue a determination as to whether the surplus is excessive. Any such review shall be undertaken in coordination with the other jurisdictions in which the corporation conducts business." for "Within 120 days after March 25, 2009, and annually thereafter, the Commissioner shall review the portion of the surplus of the corporation that is attributable to the District and shall issue a determination as to whether the surplus is excessive."; in subsec. (f), substituted "§ 31–3514 and payments and expenditures pursuant to a public-private partnership" for "§ 31–3514"; and added subsec. (j).

Temporary Amendments of Section

Section 2 of D.C. Law 18–85, in subsec. (e), "180 days" for "120 days".

Section 5(b) of D.C. Law 18–85 provides that the act shall expire after 225 days of its having taken effect.

Section 2(c) of D.C. Law 18–134, in subsec. (e), struck the first sentence and inserted "The Commissioner may, on an annual basis, and shall, on a basis no less frequently than every 3 years, review the portion of the surplus of the corporation that is attributable to the District and may issue a determination as to whether the surplus is excessive. Any such review shall be undertaken in coordination with the other jurisdictions in which the corpo-

ration conducts business."; in subsec.(f), substituted "section 15 and payments and expenditures pursuant to a public-private partnership" for "section 15"; and added subsec. (j) to read as follows:

"(j) The existence of a public-private partnership shall not preclude the Commissioner's surplus evaluation of the corporation or diminish the Commissioner's authority to issue directives to the corporation pursuant to the evaluation.".

Section 6(b) of D.C. Law 18–134 provides that the act shall expire after 225 days of its having taken effect.

Emergency Act Amendments

For temporary (90 day) amendment of section, see § 2 of Medical Insurance Empowerment Surplus Review Emergency Act of 2009 (D.C. Act 18–153, July 28, 2009, 56 DCR 6342).

For temporary (90 day) amendment of section, see § 2 of Medical Insurance Empowerment Surplus Review Congressional Review Emergency Amendment Act of 2009 (D.C. Act 18–210, October 21, 2009, 56 DCR 8487).

For temporary (90 day) amendment of section, see § 2(c) of Hospital and Medical Services Corporation Regulatory Emergency Amendment Act of 2009 (D.C. Act 18–277, January 11, 2010, 57 DCR 935).

Legislative History of Laws

For Law 18–104, see notes following § 31–205.

§ 31–3506.01. Compliance and implementation of community health reinvestment obligations.

(a) A corporation shall make available to the Commissioner such information as may be required to permit the Commissioner to verify the corporation's community health reinvestment and, if appropriate, its compliance with its plan to dedicate excess surplus or to verify that the corporation is participating in a public-private partnership. When verifying the community health reinvestment or the corporation's compliance with its plan, or when verifying the corporation's participation in a public-private partnership the Commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals, the cost of which shall be borne by the corporation.

(b) In implementing the provisions of the Medical Insurance Empowerment Amendment Act of 2008 [D.C. Law 17–369], the Commissioner shall consider the interests and needs of the jurisdictions in the corporation's service area.

(Apr. 9, 1997, D.C. Law 11–245, § 7a, as added Mar. 25, 2009, D.C. Law 17–369, § 2(e), 56 DCR 1346; Feb. 4, 2010, D.C. Law 18–104, § 2(d), 56 DCR 9182.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 18–104 rewrote subsec. (a), which had read as follows:

"(a) A corporation shall make available to the Commissioner such information as may be required to permit the Commissioner to verify the corporation's community health reinvestment and, if appropriate, its compliance with its plan to dedicate excess surplus. When verifying the community health reinvestment or the corporation's compliance with its plan, the Commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals, the cost of which shall be borne by the corporation."

Temporary Amendments of Section

Section 2(d) of D.C. Law 18–134, in subsec. (a), substituted "dedicate excess surplus or to verify that the corporation is participating in a public-private partnership" for "dedicate excess surplus" and substituted "or the corporation's compliance with its plan, or when verifying the corporation's participation in a public-private partnership" for "or the corporation's compliance with its plan,".

Section 6(b) of D.C. Law 18–134 provides that the act shall expire after 225 days of its having taken effect.

Emergency Act Amendments

For temporary (90 day) amendment of section, see § 2(d) of Hospital and Medical Services Corporation Regulatory Emergency Amendment Act of 2009 (D.C. Act 18–277, January 11, 2010, 57 DCR 935).

Legislative History of Laws

For Law 18–104, see notes following § 31–205.

§ 31–3508. Filing of subscriber contract forms and rates.

(a) *Contract form filings.* — (1) The form and content of all subscriber contracts between corporation and its contractholders issued in the District of Columbia, including any group certificates and any riders, endorsements, amendments, or other forms made a part of the subscriber contract, shall, at all times, be subject to the prior approval of the Mayor.

(2) The Mayor shall disapprove a proposed form of subscriber contract if the form contains provisions which are unjust, unfair, inequitable, inadequate, misleading, or decep-

tive, which encourage misrepresentation of the coverage, or which are otherwise not in compliance with applicable provisions of this chapter.

(3) Each subscriber contract, group certificate, or other contract form shall plainly state the services, benefits, and indemnification to which the subscriber is entitled as well as the services, benefits, and indemnification to which the subscriber is not entitled.

(4) Each proposed form of a subscriber contract shall be on file for a waiting period of 60 days before it becomes effective. When, in the Mayor's opinion, a filing is not accompanied by the information needed to support it and the Mayor does not have sufficient information to determine whether the filing meets the requirements of this section, a corporation shall be required to furnish the needed information. In such event the waiting period shall be suspended and shall recommence as of the date the information is furnished. Upon written application by the corporation, the Mayor may authorize a filing which the Mayor has reviewed to become effective before the expiration of the waiting period or any extension thereof, or at any later date. A filing shall be deemed approved unless disapproved by the Mayor within the waiting period or any extension thereof requested by the corporation.

(b) *Rate filings for individual subscriber contracts.* — All rates for individual subscriber contracts issued in the District of Columbia shall be subject to the prior approval of the Mayor. Each proposed rate filing shall be on file for a waiting period of 60 days before it becomes effective. When, in the Mayor's opinion, a rate filing is not accompanied by the information needed to support it and the Mayor does not have sufficient information to determine whether the rate filing meets the requirements of this section, a corporation shall be required to furnish the needed information. In such event, the waiting period shall be suspended and shall recommence as of the date the information is furnished. Upon written application by the corporation, the Mayor may authorize a rate filing which the Mayor has reviewed to become effective before the expiration of the waiting period or any extension thereof. A filing shall be deemed approved unless disapproved by the Mayor within the waiting period or any extension thereof requested by the corporation. All approved rate filings for individual subscriber contracts submitted in other jurisdictions shall be filed with the Mayor for information purposes only.

(c) *Rate filings for group subscriber contracts.* — All rates for group subscriber contracts, other than experience rated groups, issued in the District of Columbia shall be filed with the Mayor no later than the date on which a corporation proposes to make such rates effective. The rate filing shall be subject to review and disapproval by the Mayor for a period of 60 days after the filing date. If not disapproved before the expiration of the review period or any extension thereof requested by the corporation, the filing shall be deemed approved. Any disapproval under this subsection shall be applied retrospectively to the date the corporation made such rates effective. Upon application by the corporation, the Mayor may affirmatively approve a filing prior to the end of the review period. All approved rate filings for group subscriber contracts, other than experience rated groups, submitted in other jurisdictions shall be filed with the Mayor for information purposes only.

(d) *Contract form and rate filings generally.* — (1) Application for approval shall be made to the Mayor in the format, and with the information, that the Mayor requires.

(2) The Mayor may, at any time, require any corporation issued a certificate of authority under this chapter to demonstrate that its filings, including the terms and provisions of its subscriber contract forms, its rates, and its method for setting rates, are in compliance with this section, notwithstanding that the filings then in effect had previously been approved by the Mayor. Any subscriber contract forms and rates previously approved by the Mayor, but subsequently disapproved under this section, shall be considered disapproved on a prospective basis only from the date of such notice of disapproval, unless the corporation made a material misrepresentation in its contract form or rate filings.

(3) If at any time subsequent to the applicable waiting or review period provided for in this section, the Mayor finds that a filing does not meet the requirements of this section, the Mayor shall issue an order to the filer specifying in what respects the Mayor finds that the filing fails to meet the requirements of this section, and stating when, within a reasonable period thereafter, the filing shall be no longer effective. The order shall not affect any subscriber contract, group certificate, or other contract made or issued prior to the expiration of the period set forth in the order. However, the Mayor may, prior to

issuing the order and if requested by the filer, hold a hearing upon not less than 10 days written notice to the filer specifying the matters to be considered at the hearing.

(e) *Rate filings generally.* — (1) Rate filings shall be inclusive of all rates, rating plans, and other documents utilized by a corporation to determine rates.

(2) Rates shall not be excessive, inadequate, or unfairly discriminatory in relation to the services and benefits offered.

(3) In determining whether to disapprove a rate filing, the Mayor shall give due consideration to past and prospective loss experience within and outside the District of Columbia, to underwriting practice and judgment to the extent appropriate, to a reasonable margin for surplus needs, to past and prospective expenses both nationwide and within the District of Columbia, and to all other relevant factors within and outside the District of Columbia. In establishing the rates to be charged individuals with open enrollment subscriber contracts, including individual conversion subscriber contracts, the revenue which would have been otherwise collected by the District of Columbia government through the imposition of the 1% premium tax pursuant to § 31–3514(j), but which a corporation has contributed to a Rate Stabilization Fund in accordance with § 31–3514(j)(1), shall be credited by the corporation to the benefit of this class of subscribers in an amount which assures competitive rates.

(4) A corporation filing a rate pursuant to this section shall also comply with the Reasonable Health Insurance Ratemaking Reform Act of 2010 [D.C. Law 18–360].

(f) *Transition provision for contract forms and rates.* — (1) As to any corporation heretofore existing and operating on April 9, 1997, and subject to § 31–3523, all subscriber contracts, group certificates, and other contracts issued in the District of Columbia after April 9, 1997, shall be on forms that have been filed and approved under this chapter. The requirement of this section shall not affect the validity of subscriber contracts, group certificates, and other contracts issued in the District of Columbia by such a corporation which are outstanding on April 9, 1997, and have not previously been filed with and approved by the Mayor, but these contracts shall be replaced, at the next contract anniversary date following April 9, 1997, by forms filed and approved under this chapter.

(2) As to any corporation heretofore existing and operating on April 9, 1997, and subject to § 31–3523, all rates applied to subscriber contracts after April 9, 1997 shall be such rates as have been filed and approved under this chapter. The requirements of this section shall not affect the validity of rates applied to subscriber contracts issued by such a corporation which are outstanding on April 9, 1997, and have not previously been filed with and approved by the Mayor, but these rates shall be replaced, at the next contract anniversary date following April 9, 1997, by rates filed and approved under this chapter.

(g) A corporation whose proposed form of subscriber contract or proposed contract rate has been disapproved by the Mayor may contest the Mayor's action in accordance with the procedures of § 31–3522.

(Apr. 9, 1997, D.C. Law 11–245, § 9, 44 DCR 1158; Apr. 8, 2011, D.C. Law 18–360, § 503(b), 58 DCR 896.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 18–360 added subsec. (e)(4).

Emergency Act Amendments

For temporary (90 day) amendment of section, see § 3 of Reasonable Health Insurance Premium Increase Emergency Amendment Act of 2010 (D.C. Act 18–328, March 18, 2010, 57 DCR 2546).

Legislative History of Laws

For history of Law 18–360, see notes under § 31–2231.11.

§ 31–3514. Open enrollment.

(a) A corporation issued a certificate of authority under this chapter shall make available to citizens of the District of Columbia an open enrollment program under the terms set forth in this section.

(b) As used in this section, the term:

(1) "Comprehensive individual subscriber contracts" means subscriber contracts, conforming to the requirements of subsection (g) of this section, which are issued to provide

basic hospital and medical services, or to provide benefits and indemnification for such services.

(2) "Open enrollment subscriber contracts" means comprehensive individual subscriber contracts issued pursuant to an open enrollment program by a corporation which has a certificate of authority under this chapter and provides coverage to individuals.

(c) A corporation's open enrollment program shall provide for the issuance of open enrollment subscriber contracts without imposition by the corporation of underwriting criteria whereby coverage is denied or subject to cancellation or nonrenewal, in whole or in part, because of an individual's age, health history, medical history, employment status, or, if employed, industry or job classification.

(d) A corporation's open enrollment program shall make open enrollment subscriber contracts available to any individual residing in the District of Columbia, except, that this requirement shall not apply to any individual who is eligible for coverage as an employee of an employer which provides, in whole or in part, basic hospital and medical services, benefits, and indemnification coverage to its employees.

(e) A corporation's open enrollment program shall be available on a year-round basis.

(f) Repealed.

(g) The Mayor may prescribe minimum standards to govern the contents of comprehensive individual subscriber contracts issued pursuant to this section. Such minimum standards shall ensure that these contracts provide hospital and medical services, or benefits and indemnification for a comprehensive range of health care needs without qualifying exclusions that fail to protect the subscriber under normal circumstances. Such minimum standards shall also ensure that the option of obtaining comprehensive individual subscriber contract coverage is made available to all individuals included within the definition of "open enrollment subscriber contracts" in subsection (b)(2) of this section.

(h) The Mayor may prescribe minimum standards specifically to govern the content of comprehensive individual subscriber contracts issued to individuals who have converted from group subscriber contracts to individual coverage because of termination of the individual's eligibility for group coverage.

(i) A corporation issued a certificate of authority under this chapter shall provide other public services in the District of Columbia consisting of health-related educational support for residents of the corporation's service area who, based upon such educational support, may experience a lesser need for hospital and medical services, or benefits and indemnification for such services.

(j)(1) A corporation shall maintain a separately established rate stabilization fund ("RS Fund") to be used solely to subsidize open enrollment subscribers pursuant to subsections (c) and (d) of this section. A corporation shall deposit an amount necessary and appropriate to maintain the open enrollment program of the corporation pursuant to subsection (k)(1) of this section; provided, that the corporation shall not deduct an aggregate amount exceeding $550,000 of its payment to the RS Fund from the amount otherwise due by the corporation under § 31–205 or § 47–2608(a). The RS Fund shall not be used to pay marketing or promotional expenses associated with the program. Unless the corporation elects to terminate the RS Fund pursuant to subsection (k)(3) of this section, the corporation shall carry over from year to year all unexpended funds in the RS Fund, including interest earned on investment of the funds in the RS Fund.

(2) In the rate filings for the open enrollment program required by § 31–3508, a corporation shall provide documentation to the Mayor confirming the existence of the RS Fund, identifying the amounts paid from the RS Fund to subsidize open enrollment rates, and specifying the RS Fund balance at year end and as of the date of the corporation's filing. The Mayor shall order annually an independent audit of the RS Fund, the expenses of which shall be paid by the corporation. If the Mayor determines, with or without an audit, that all or any portion of the money in the RS Fund is not being used to subsidize open enrollment rates or is not being reasonably set aside in anticipation of projected subsidies of open enrollment rates in future years, the Mayor may order the corporation to pay the revenue not being so used or set aside to the Healthy DC and Health Care Expansion Fund established by § 31–3514.02.

(k) A corporation shall continue to offer the program to each subscriber as long as the subscriber renews his or her coverage under the program.

(l) Any proposed rates filed by a corporation with the Mayor pursuant to § 31–3508 which are to be applied to open enrollment subscriber contracts, including individual conversion subscriber contracts, shall include a factor crediting for the benefit of this class of subscribers in an amount which assures competitive rates, the revenue which would have been otherwise collected by the District of Columbia government as a premium tax pursuant to § 31–3514(j).

(m) The open enrollment program shall maintain the following affordability and adequacy criteria for individual participants:

(1) Annual premium costs shall not exceed 125% of standard individual market rates and shall be determined once every 12 months.

(2) Cost sharing, deductibles, and co-insurance shall not exceed those in the corporation's most popular policy available to small employers in the District.

(3) Subscriber contracts shall not contain service limitations or lifetime or annual benefit maximums.

(4) Subscriber contracts and contract forms shall be subject to § 31–3508.

(5) Subscriber contracts and contract forms shall not contain exclusions or riders for pre-existing conditions.

(n) A corporation shall prominently advertise the availability of its open enrollment subscriber contracts continuously on the Internet and at least quarterly in a newspaper of general circulation throughout the District. The content and format of the advertising shall be filed with the Commissioner no less than 30 days before its appearance in a newspaper or on the Internet.

(o) The corporation shall make the open enrollment program available for a minimum of 2500 subscribers. The corporation shall submit a report annually on October 1 to the Commissioner on the number of subscribers enrolled.

(p) In lieu of the requirements of subsection (m) through (o) of this section, the corporation may enter into a public-private partnership.

(q) The corporation shall submit an annual report to the Mayor regarding the open enrollment program. The Mayor shall determine the format and content of the report; provided, that the report shall include:

(1) Membership distribution by:
- (A) Age
- (B) Gender;
- (C) Ward;
- (D) Zip code;
- (E) Race/ethnicity;
- (F) Income; and
- (G) The amount of time in the program;

(2) The number of members by contract type;

(3) Program expenditures for:
- (A) Inpatient services;
- (B) Outpatient services;
- (C) Behavioral health services; and
- (D) Prescription drugs;

(4) Average premium;

(5) Premium levels by age; and

(6) The number of members that have reached the:
- (A) Out-of-pocket maximum expenditure; and
- (B) Annual prescription drug benefit maximum.

(r) The public-private partnership shall be certified by January 31, 2010.

(Apr. 9, 1997, D.C. Law 11–245, § 15, 44 DCR 1158; June 11, 2004, D.C. Law 15–166, § 4(u)(3), 51 DCR 2817; Mar. 2, 2007, D.C. Law 16–192, § 5012(b), 53 DCR 6899; Mar. 25, 2009, D.C. Law 17–369, § 2(f), 56 DCR 1346; Feb. 4, 2010, D.C. Law 18–104, § 2(e), 56 DCR 9182; Sept. 24, 2010, D.C. Law 18–223, § 5023(b), 57 DCR 6242.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 18–104 added subsecs. (p), (q) and (r).

D.C. Law 18–223, in subsec. (j)(2), substituted "Healthy DC and Health Care Expansion Fund" for "Healthy DC Fund".

Temporary Amendments of Section

Section 2(e) of D.C. Law 18–134 added subsecs. (p), (q),and (r) to read as follows:

"(p) In lieu of the requirements of subsection (m) through (o) of this section, the corporation may enter into a public-private partnership.

"(q) The corporation shall submit an annual report to the Mayor regarding the open enrollment program. The Mayor shall determine the format and content of the report; provided, that the report shall include:

"(1) Membership distribution by:

"(A) Age

"(B) Gender;

"(C) Ward;

"(D) Zip code;

"(E) Race/ethnicity;

"(F) Income; and

"(F) The amount of time in the program;

"(2) The number of members by contract type;

"(3) Program expenditures for:

"(A) Inpatient services;

"(B) Outpatient services;

"(C) Behavioral health services; and

"(D) Prescription drugs;

"(4) Average premium;

"(5) Premium levels by age; and

"(6) The number of members that have reached the:

"(A) Out-of-pocket maximum expenditure; and

"(B) Annual prescription drug benefit maximum.

"(r) The public-private partnership shall be certified by January 31, 2010.".

Section 6(b) of D.C. Law 18–134 provides that the act shall expire after 225 days of its having taken effect.

Section 3(b) of D.C. Law 18–205, in subsec. (j)(2), substituted "Healthy DC and Health Care Expansion Fund" for "Healthy DC Fund".

Section 7(b) of D.C. Law 18–205 provides that the act shall expire after 225 days of its having taken effect.

Section 201(b) of D.C. Law 18–271, in subsec. (d), substituted "District of Columbia who is ineligible for the DC High Risk Pool Program," for "District of Columbia,".

Section 301(b) of D.C. Law 18–271 provides that the act shall expire after 225 days of its having taken effect.

Temporary Addition of Section

Section 3 of D.C. Law 18–85 added a section to read as follows:

"Sec 2a. Applicability.

"Section 2(f) shall not apply until 90 days after the Commissioner completes his surplus review as required by section 2(e) and transmits a copy of the determination to the Council. This section shall apply as of March 25, 2009."

Section 5(b) of D.C. Law 18–85 provides that the act shall expire after 225 days of its having taken effect.

Emergency Act Amendments

For temporary (90 day) addition, see § 3 of Medical Insurance Empowerment Surplus Review Emergency Act of 2009 (D.C. Act 18–153, July 28, 2009, 56 DCR 6342).

For temporary (90 day) addition, see § 3 of Medical Insurance Empowerment Surplus Review Congressional Review Emergency Amendment Act of 2009 (D.C. Act 18–210, October 21, 2009, 56 DCR 8487).

For temporary (90 day) amendment of section, see § 2(e) of Hospital and Medical Services Corporation Regulatory Emergency Amendment Act of 2009 (D.C. Act 18–277, January 11, 2010, 57 DCR 935).

For temporary (90 day) amendment of section, see § 3(b) of Medicaid Resource Maximization Emergency Amendment Act of 2010 (D.C. Act 18–390, May 7, 2010, 57 DCR 4339).

For temporary (90 day) amendment of section, see § 201(b) of DC High Risk Pool Program Establishment Emergency Act of 2010 (D.C. Act 18–522, August 3, 2010, 57 DCR 8001).

For temporary (90 day) amendment of section, see § 5023(b) of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–104, see notes following § 31–205.

For Law 18–223, see notes following § 31–101.

§ 31–3514.02. Establishment of Healthy DC and Health Care Expansion Fund.

(a) There is established as a nonlapsing fund the Healthy DC and Health Care Expansion Fund ("Fund"). All funds deposited into the Fund, and any interest earned on those funds,

shall not revert to the unrestricted fund balance of the General Fund of the District of Columbia at the end of a fiscal year, or at any other time, but shall be continually available to support the Healthy DC Program, established by Chapter 6A of Title 4, and other medical assistance programs administered by the Department of Health Care Finance, without regard to fiscal year limitation, subject to authorization by Congress.

(b) There shall be deposited into the Fund:

(1) All tax revenue generated pursuant to § 31–3514.01;

(2) Any other local funds, including any fees, penalties, or other tax revenues required by District law, including the premium tax imposed on health maintenance organizations, as required by § 31–3403.01.

(3) Annual appropriations, if any;

(4) Federal grant funds;

(5) All fines and penalties collected pursuant to Chapter 6A of Title 4; and

(6) Grants, gifts, or subsidies from public or private sources.

(c) Notwithstanding subsection (a) of this section, for fiscal year 2010, up to $3.25 million from the Fund shall be utilized to support the following one-time allocations:

(1) An amount of $2.5 million shall support a grant to an acute care pediatric hospital in the District for the purpose of supporting operational expenses associated with the new pediatric emergency facility located at the United Medical Center; and

(2) Up to $750,000 to support operational expenses associated with the delivery of health care services at the D.C. Jail.

(Apr. 9, 1997, D.C. Law 11–245, § 15b, as added Mar. 2, 2007, D.C. Law 16–192, § 5012(c), 53 DCR 6899; Aug. 16, 2008, D.C. Law 17–219, § 5050, 55 DCR 7598; Mar. 25, 2009, D.C. Law 17–353, § 138, 56 DCR 1117; Mar. 3, 2010, D.C. Law 18–111, § 5131, 57 DCR 181; Sept. 24, 2010, D.C. Law 18–223, § 5023(c), 57 DCR 6242.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 18–111 added subsec. (c).

D.C. Law 18–223, in the section heading, substituted "Healthy DC and Health Care Expansion Fund" for "Healthy DC Fund"; in subsec. (a), substituted "Healthy DC and Health Care Expansion Fund ('Fund')" for "Healthy DC Fund ('Fund')" and inserted ", and other medical assistance programs administered by the Department of Health Care Finance,"; and rewrote subsec. (b)(2), which had read as follows:

"(2) Any other local funds, including any fees, penalties, or other tax revenue required by District law, including a portion of the premium tax imposed on health maintenance organizations, as required by Chapter 34 of this title;"

Temporary Amendments of Section

Section 2 of D.C. Law 18–154, in subsec. (a), substituted ", and any other purpose as set forth in this section, without regard" for "without regard"; and added subsec. (c) to read as follows:

"(c)(1) Notwithstanding subsection (a) of this section, the Mayor is authorized to utilize, in fiscal year 2010, up to $5.9 million from the Fund to support the delivery of acute care services for uninsured or under-insured individuals at United Medical Center; provided, that:

"(A) An amount of $3 million be distributed by March 2, 2010; and

"(B) Up to $2.9 million be distributed, in equal monthly installments, beginning by March 15, 2010, and continuing through to September 30, 2010.

"(2) United Medical Center shall submit a quarterly report to the Mayor providing an accounting of any funds received pursuant to this subsection, including a detailed account of the acute care services that were provided.

"(3)(A) The Mayor shall seek to recoup any funds from United Medical Center that the Mayor determines were expended contrary to the authority granted by this subsection.

"(B) The Mayor may conduct an audit of the uncompensated acute care expenditures, if necessary, to verify that the funds were expended in accordance with this subsection.

"(4) The Department of Health Care Finance shall have grant-making authority for purposes of effectuating this subsection.".

Section 8(b) of D.C. Law 18–154 provides that the act shall expire after 225 days of its having taken effect.

Section 3(c) of D.C. Law 18–205, in the section heading, substituted "Healthy DC and Health Care Expansion Fund" for "Healthy DC Fund"; in subsec. (a), substituted "Healthy DC and Health Care Expansion Fund ('Fund')" for "Healthy DC Fund ('Fund')" and substituted " Title 4, and other medical assistance programs administered by the Department of Health Care Finance, without" for "Title 4 without"; and rewrote subsec. (b)(2) to read as follows:

"(2) Any other local funds, including any fees, penalties, or other tax revenues required by District law, including the premium tax imposed on health maintenance organizations, as required by section 4a of the Health Maintenance Organization Act of 1996, effective August 16, 2008 (D.C. Law 17–219; D.C. Official Code § 31–3403.01).".

Section 7(b) of D.C. Law 18–205 provides that the act shall expire after 225 days of its having taken effect.

Emergency Act Amendments

For temporary (90 day) amendment of section, see § 5131 of Fiscal Year 2010 Budget Support Second Emergency Act of 2009 (D.C. Act 18–207, October 15, 2009, 56 DCR 8234).

For temporary (90 day) amendment of section, see § 5131 of Fiscal Year Budget Support Congressional Review Emergency Amendment Act of 2009 (D.C. Act 18–260, January 4, 2010, 57 DCR 345).

For temporary (90 day) amendment of section, see § 2 of Healthy DC Equal Access Fund and Hospital Stabilization Emergency Amendment Act of 2009 (D.C. Act 18–310, February 18, 2010, 57 DCR 1635).

For temporary (90 day) amendment of section, see § 3(c) of Medicaid Resource Maximization Emergency Amendment Act of 2010 (D.C. Act 18–390, May 7, 2010, 57 DCR 4339).

For temporary (90 day) amendment of section, see § 5023(c) of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

Law 18–111, the "Fiscal Year 2010 Budget Support Act of 2009", was introduced in Council and assigned Bill No. 18–203, which was referred to the Committee on the Whole. The bill was adopted on first and second readings on May 12, 2009, and September 22, 2009, respectively. Signed by the Mayor on December 18, 2009, it was assigned Act No. 18–255 and transmitted to both Houses of Congress for its review. D.C. Law 18–111 became effective on March 3, 2010.

For Law 18–223, see notes following § 31–101.

Miscellaneous Notes

Short title: Section 5130 of D.C. Law 18–111 provided that subtitle N of title V of the act may be cited as the "Hospital and Medical Services Corporation Regulatory Amendment Act of 2009".

Chapter 37

Medicare Supplement Insurance.

Subchapter I. General.

Section
31–3710. Rules.

SUBCHAPTER I. GENERAL.

§ 31–3710. Rules.

Historical and Statutory Notes

Resolutions

Resolution 18–298, the "Medicare Supplement Insurance Minimum Standards Approval Resolution of 2009", was approved effective November 3, 2009.

SUBTITLE V

LIABILITY AND RELATED INSURANCE.

Chapter 39A

Captive Insurance Companies (2004).

Subchapter I. General.

Section
31–3931.03. Organizational requirements for transacting business; incorporation.
31–3931.06. Capital and surplus.
31–3931.07. Investments.
31–3931.13. Annual report.
31–3931.22. Applicable laws.

SUBCHAPTER I. GENERAL.

§ 31–3931.03. Organizational requirements for transacting business; incorporation.

(a) A captive insurer may be organized in the District in any form of authorized by the Commissioner.

(a–1) The articles of incorporation of a captive insurer shall become effective when approved by the Commissioner.

(b) The articles of incorporation or organizational documents of a captive insurer shall satisfy the following minimum requirements:

(1) The capital stock of a captive insurer incorporated as a stock insurer shall be issued at not less than par value;

(2) The captive insurer shall not have less than 2 incorporators or organizers;

(3) The articles of association, articles of incorporation, articles of organization, charter, or bylaws of a captive insurer shall require a quorum of the board of directors that consists of more than ⅓ of the number of directors prescribed by the articles of association, articles of incorporation, articles of organization (or equivalent organizational document), charter, or bylaws; and

(4) Any additional provisions that the Commissioner considers necessary.

(c) The Commissioner may, at the request of the captive insurer, issue a certificate of good standing and charge a fee for each certificate in an amount to be established by the Commissioner.

(d) An attorney-in-fact of a reciprocal captive insurer may be organized in the District in any form of business, including as an individual, authorized by the Commissioner.

(e) A captive insurer organized in the District shall have the privileges of, and shall be subject to, the provisions of Chapters 1, 2, 3, 4, and 8 of Title 29. If the provisions of this chapter conflict with the general provisions of Title 29, the provisions of this chapter shall control.

(f) The Commissioner may regulate the manager of a captive insurer.

(Mar. 17, 2005, D.C. Law 15–262, § 4, 52 DCR 1205; Mar. 2, 2007, D.C. Law 16–191, § 54(b), 53 DCR 6794; July 2, 2011, D.C. Law 18–378, § 3(w), 58 DCR 1720; Mar. 14, 2012, D.C. Law 19–103, § 2(a), 59 DCR 432.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 18–378, in subsec. (e), substituted "Chapters 1, 2, 3, 4, and 8 of Title 29" for "general corporation law set forth in Chapter 1 of Title 29, subchapter I of Chapter 3 of Title 29, and Chapter 10 of Title 29, and the applicable provisions contained in this chapter", and substituted "general provisions in Title 29" for "general provisions of the acts codified in Title 29".

D.C. Law 19–103 added subsec. (a–1).

Legislative History of Laws

For history of Law 18–378, see notes under § 31–754.

Law 19–103, the "Captive Insurance Company Amendment Act of 2012", was introduced in Council and assigned Bill No. 19–149, which was referred to the Committee on Public Services and Consumer Affairs. The Bill was adopted on first and second readings on December 6, 2011, and January 4, 2012, respectively. Signed by the Mayor on January 20, 2012, it was assigned Act No. 19–278 and transmitted to both Houses of Congress for its review. D.C. Law 19–103 became effective on March 14, 2012.

§ 31–3931.06. Capital and surplus.

(a) In addition to any other capital required to be maintained pursuant to subsection (c) of this section, a captive insurer, authorized to do business in the District, shall at all times maintain a minimum unimpaired capital of $100,000.

(b) Except as otherwise provided by the Commissioner pursuant to subsection (c) of this section, the capital required to be maintained pursuant to this section shall be in the form of cash or an irrevocable letter of credit.

(c) The Commissioner may require a captive insurer, including each segregated account, to maintain additional unimpaired capital based on the type, volume, and nature of the insurance business that is transacted by the captive insurer and may determine the amount of capital, if any, that may be in the form of an irrevocable letter of credit.

(d) A letter of credit used by a captive insurer or segregated account as evidence of capital required pursuant to this section shall:

(1) Be issued by a bank chartered in the District or by a branch of a bank located in the District if such bank is a member of the United States Federal Reserve System, or its deposits are insured by the Federal Deposit Insurance Corporation;

(2) Be issued on a form approved by the Commissioner; and

(3) Include a provision pursuant to which a letter of credit is automatically renewed each year.

(e) The Commissioner may approve an ongoing plan for the payment of dividends or other distributions by a captive insurer or segregated account if, at the time of each payment or distribution, the amount of capital and surplus retained by the captive insurer or segregated account is in excess of the amounts required by the Commissioner. The Commissioner shall adopt by rule:

(1) A specific amount that a captive insurer or segregated account must have in excess capital and surplus for the approval of an ongoing plan for the payment of dividends or other distributions; or

(2) A formula pursuant to which the specific amount of required excess capital and surplus may be calculated.

(f) A captive insurer shall not be issued a certificate of authority, and shall not hold a certificate of authority, unless the captive insurer has and maintains, in addition to any other surplus required to be maintained pursuant to subsection (h) of this section, an unencumbered surplus of:

(1) For a pure captive insurer, not less than $150,000;

(2) For an association captive insurer incorporated as a stock insurer, not less than $300,000;

(3) For an agency captive insurer, not less than $300,000;

(4) For a rental captive insurer, not less than $300,000;

(5) For an association captive insurer incorporated as a mutual insurer or reciprocal insurer, not less than $500,000; and

(6) For each segregated account, not less than an amount to be established by the Commissioner.

(g) Except as otherwise provided by the Commissioner pursuant to subsection (c) of this section, the surplus required to be maintained pursuant to this section shall be in the form of cash or an irrevocable letter of credit.

(h) The Commissioner may prescribe additional requirements relating to surplus based on the type, volume, and nature of the insurance business that is transacted by a captive insurer or segregated account and requirements regarding which surplus, if any, may be in the form of an irrevocable letter of credit.

(i) A letter of credit used by a captive insurer or a segregated account as evidence of surplus required pursuant to this section shall meet the same requirements as a letter of credit issued for paid-in capital found subsection (d) of this section.

(j) The parent of a branch captive insurer shall be subject to the jurisdiction of the United States District Court for the District of Columbia for all matters involving the branch captive insurer.

(k) Except as otherwise provided in this section, a captive insurer or segregated account shall pay dividends out of, or make any other distribution from, its capital or surplus, or both, in accordance with the provisions set forth in subsection (e) of this section. A captive insurer or segregated account shall not pay dividends out of, or make any other distribution out of, its capital or surplus or both, in violation of this section unless the captive insurer or segregated account has obtained the prior written approval of the Commissioner to make the a payment or distribution.

(l) Section 31–2502.12 shall apply to risk retention groups licensed as captive insurers. A risk retention group subject to this section may petition the Commissioner for a waiver of the limitation on exposure to risks or hazards. The Commissioner may issues rules, pursuant to § 31–3931.21, establishing the circumstances under which a risk retention group may obtain, and the conditions a risk retention group shall satisfy to obtain, a waiver of the limitation.

(Mar. 17, 2005, D.C. Law 15–262, § 7, 52 DCR 1205; Mar. 14, 2012, D.C. Law 19–103, § 2(b), 59 DCR 432.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 19–103 added subsec. (l).

Legislative History of Laws

For history of Law 19–103, see notes under § 31–3931.03.

§ 31–3931.07. Investments.

(a) A captive insurer shall file with the Commissioner a schedule of its proposed investments, and any material changes thereto, which the Commissioner may approve if he or she determines that the investments do not threaten the solvency or liquidity of the captive insurer. The Commissioner shall not unreasonably disapprove the investments.

(b) A captive insurer or segregated account may make a loan to its parent or affiliated company if the loan:

(1) Is first approved in writing by the Commissioner;

(2) Is evidenced by a note that is in a form that is approved by the Commissioner; and

(3) Does not include any money that has been set aside as capital or surplus as required by § 31–3931.06(a) or (f).

(c) Notwithstanding subsection (b) of this section, a risk retention group licensed as a captive insurer shall be subject to subchapters I, II, and V of Chapter 13A of this title.

(Mar. 17, 2005, D.C. Law 15–262, § 8, 52 DCR 1205; Mar. 14, 2012, D.C. Law 19–103, § 2(c), 59 DCR 432.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 19–103 added subsec. (c).

Legislative History of Laws

For history of Law 19–103, see notes under § 31–3931.03.

§ 31–3931.13. Annual report.

(a) On or before March 2 of each year, a captive insurer shall submit to the Commissioner, on a form prescribed by the Commissioner by regulation, a report of its financial condition, as prepared by a certified public accountant. A captive insurer shall file a consolidated report on behalf of each of its segregated accounts. A captive insurer shall use generally accepted accounting principles and include any useful or necessary modifications or adaptations thereof that have been approved or accepted by the Commissioner for the type of insurance and kinds of insurers to be reported upon, as supplemented by additional information required by the Commissioner.

(b) A pure captive insurer may apply, in writing, for authorization to file its annual report based on a fiscal year that is consistent with the fiscal year of the parent company of the pure captive insurer. If an alternative date is granted:

(1) The annual report shall be due not later than 60 days after the end of each fiscal year; and

(2) The pure captive insurer shall file on or before March 2 of each year such forms as required by the Commissioner by regulation to provide sufficient detail to support its premium tax return filed pursuant to § 31–3931.12.

(c) All risk retention groups licensed as captive insurers shall comply with Chapter 3 of this title, except that the exemption in § 31–314(a) shall not apply to risk retention groups. All

risk retention groups licensed as captive insurers shall comply with the actuarial opinion filing requirements set forth in §§ 31–2502.26a and 31–2502.26b.

(Mar. 17, 2005, D.C. Law 15–262, § 14, 52 DCR 1205; Mar. 14, 2012, D.C. Law 19–103, § 2(d), 59 DCR 432.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 19–103 added subsec. (c).

Legislative History of Laws

For history of Law 19–103, see notes under § 31–3931.03.

§ 31–3931.22. Applicable laws.

(a) Except as otherwise expressly provided in this chapter, only the following laws relating to insurance shall apply to risk retention groups licensed as captive insurers:

(1) Chapter 4 of this title notwithstanding the definition of the term "licensed insurer" or "insurer" in § 31–3931.01(7)(A);

(2) Subchapter I of Chapter 7 of this title;

(3) Chapter 15 of this title; and

(4) Chapter 18 of this title.

(b) Except for §§ 31–2002(a)(2) and 31–2003(f), Chapter 20 of this title shall, effective January 1, 2012, apply to risk retention groups licensed as captive insurers; provided, that the Commissioner may waive the requirement that a risk retention group licensed as a captive insurer file a Risk Based Capital Plan under Chapter 20 of this title if the insurer is in compliance with its approved plan of operation and any additional requirements imposed by the Commissioner by rule pursuant to § 31–3931.21.

(Mar. 17, 2005, D.C. Law 15–262, § 23, 52 DCR 1205; Mar. 14, 2012, D.C. Law 19–103, § 2(e), 59 DCR 432.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 19–103 rewrote the section, which formerly read:

"Except as provided in this chapter, no law relating to the insurance industry shall apply to captive insurers other than this chapter."

Legislative History of Laws

For history of Law 19–103, see notes under § 31–3931.03.

SUBTITLE VI

LIFE AND RELATED INSURANCE.

Subdivision A. Life Insurance Act.

Chapter 43

Department of Insurance, Securities and Banking With Respect to Life Companies.

Subdivision A. Life Insurance Act.

Section

31–4314. False statements in application for policy.

§ 31–4314. False statements in application for policy.

Notes of Decisions

1. Construction and application

District of Columbia statute addressing false statements in applications for insurance policies did not apply to insurer's denial of coverage for legal malpractice claim against law firm under firm's claims-made professional liability policy, which was based upon exclusion that barred coverage for claim where insured, prior to policy's inception date, had basis to believe that act or omission underlying claim might reasonably be expected to be the basis of a claim, rather than upon any assertion that firm made false statement in its insurance application, causing policy to be void or not in effect. Ross v. Continental Cas. Co., 2009, 420 B.R. 43, affirmed 393 Fed.Appx. 726, 2010 WL 3721542. Insurance ⟹ 2266; Insurance ⟹ 2998

2. Law governing

Under District of Columbia law, provision in life insurance policy application that policy would not take effect unless applicant was actually in the state of health and insurability represented in the application was invalid and could not be used to rescind policy of insured on grounds that he failed to disclose his history of prescription drug use and various medical consultations; under condition, any misstatement, whether made in good or bad faith and whether material or immaterial to insurer, would render the policy void, thereby nullifying protections afforded to insured in District of Columbia Code prohibiting insurer from voiding policy unless applicant's misrepresentations were made with the intent to deceive or were material to insurer's decision making process. Thorpe v. Banner Life Ins. Co., 2009, 632 F.Supp.2d 8. Insurance ⟹ 3003(1); Insurance ⟹ 3003(8)

4. False statements

Genuine issues of material fact as to whether insured's false statement on his life insurance policy application, which did not reveal that he had filled many prescriptions for a variety of medications, including pain killers, muscle relaxers, sleep aids, and antidepressants, within the five years preceding his application, was material to the insurer's decision as to whether and at what rate to insure, and thus whether insurer had right to rescind the policy under District of Columbia law, precluded summary judgment on beneficiary's breach of contract action challenging insurer's refusal to pay under the policy following insured's death. Thorpe v. Banner Life Ins. Co., 2009, 632 F.Supp.2d 8. Federal Civil Procedure ⟹ 2501

14. Summary judgment

Genuine issues of material fact as to whether insured's false statement on his life insurance policy application, that within the previous ten years he had not been treated or diagnosed by a member of the medical profession as having backache, was material to the insurer's decision as to whether and at what rate to insure, and thus whether insurer had right to rescind the policy under District of Columbia law, precluded summary judgment on beneficiary's breach of contract action challenging insurer's refusal to pay under the policy following insured's death. Thorpe v. Banner Life Ins. Co., 2009, 632 F.Supp.2d 8. Federal Civil Procedure ⟹ 2501

Chapter 47

Provisions Relating to All Life Insurance Companies.

Section

31–4712. Accident and sickness policies.

§ 31–4712. Accident and sickness policies.

(a) *Filing requirements.* — No policy of insurance against loss resulting from sickness or from bodily injury or death by accident, or both, shall be issued or delivered to any person in the District by any company organized under this or any other law of the District, or, if a foreign or alien company, authorized to do business in the District, including, but not limited to, all Health Maintenance Organizations, Group Hospitalization and Medical Services, Inc., all life insurance companies licensed to do business in the District, and all for-profit as well as nonprofit health insurers issuing or delivering expense incurred accident and sickness health insurance policies and certificates, until a copy of the form thereof, and of the classification of risks and the premium rates appertaining thereto, have been filed with the Commissioner; nor shall it be so issued or delivered until the expiration of 30 days after it has been so filed, unless the Commissioner shall sooner give his written approval thereto. If the Commissioner shall give written notice to the company which has filed such form that it does not comply with the requirements of law, specifying the reasons for his opinion, it shall be unlawful thereafter for any such insurer to issue any policy in such form. Rates filed with respect to a

policy or certificate subject to the Reasonable Health Insurance Ratemaking Reform Act of 2010 [Chapters 30A, 31C, and 33A of this title] shall also comply with the provisions of such act.

(b) *Form.* — (1) No policy of accident and sickness insurance shall be delivered or issued for delivery to any person in the District unless:

(A) The entire money and other considerations therefor are expressed therein;

(B) The time at which the insurance takes effect and terminates is expressed therein;

(C) It purports to insure only 1 person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the policyholder, any 2 or more eligible members of that family, including spouse, domestic partner, dependent children or any children under a specified age which shall not exceed 19 years and any other person dependent upon the policyholder;

(D) The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in lightfaced type of a style in general use, the size of which shall be uniform and not less than 10–point with a lowercase unspaced alphabet length not less than 120–point (the text shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions);

(E) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in subsection (c) of this section, are printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "EXCEPTIONS," or "EXCEPTIONS AND REDUCTIONS"; provided, that, if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies;

(F) Each such form, including riders and endorsements, shall be identified by a former number in the lower left-hand corner of the 1st page thereof;

(G) It contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the Commissioner;

(H) It contains no provision which would restrict access to psychologists or optometrists. When a policy relating to health insurance requires payment or reimbursement for services which may be performed by a duly licensed psychologist or optometrist, any person covered by the policy shall be free to select and have direct access to such psychologist or optometrist without supervision or referral by a practitioner of the healing art and shall be entitled, under the policy, to have payment or reimbursement made for services performed;

(I) For a policy issued or renewed after April 15, 1995, it contains a provision covering a minor grandchild, niece, or nephew of an employee of the District of Columbia if the minor grandchild, niece, or nephew is under the primary care of the insured, and if the legal guardian of the minor grandchild, niece, or nephew, if other than the insured, is not covered by an accident or sickness policy. For the purposes of this paragraph, the term "primary care" means that the insured provides food, clothing, and shelter, on a regular and continuous basis, for the minor grandchild, niece, or nephew during the time that the District of Columbia public schools are in regular session; and

(J) For a policy issued or renewed after April 15, 1996, it contains a provision covering a minor grandchild, niece, or nephew under the primary care of the insured, and if the legal guardian of the minor grandchild, niece, or nephew, if other than the insured, is not covered by an accident or sickness policy. For the purposes of this paragraph, the term "primary care" means that the insured provides food, clothing, and shelter, on a regular and continuous basis, for the minor grandchild, niece, or nephew during the time that the District of Columbia public schools are in regular session.

(2) If any policy is issued by an insurer domiciled in the District for delivery to a person residing in another jurisdiction, and if the official having responsibility for the administration of the insurance laws of such other jurisdiction shall have advised the Commissioner that any such policy is not subject to approval or disapproval by such official, the

Commissioner may by ruling require that such policy meet the standards set forth in paragraph (1) of this subsection and in subsection (c) of this section.

(c) *Provisions.* —

(1) *Required provisions.* — Except as provided in paragraph (3) of this subsection each such policy delivered or issued for delivery to any person in the District shall contain the provisions specified in this paragraph in the words in which the same appear in this paragraph; provided, however, that the insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the Commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this paragraph or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Commissioner may approve:

(A) A provision as follows:

"ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.".

(B)(i) A provision as follows:

"TIME LIMIT ON CERTAIN DEFENSES: After 3 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such 3–year period.".

(ii) (The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial 3–year period, nor to limit the application of subparagraphs (A), (B), (C), (D), and (E) of paragraph (2) of this subsection in the event of misstatement with respect to age or occupation or other insurance.)

(iii) A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age 50 or in the case of a policy issued after age 44, for at least 5 years from its date of issue; may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption "INCONTESTABLE."

"After this policy has been in force for a period of 3 years during the lifetime of the insured (excluding any period during which the insured has a disability), it shall become incontestable as to the statements contained in the application."

"No claim for loss incurred or disability (as defined in the policy) commencing after 3 years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy."

(C)(i) A provision as follows:

"GRACE PERIOD: A grace period of . . . (insert a number not less than '7' for weekly premium policies, '10' for monthly premium policies, and '31' for all other policies) days will be granted for the payment of each premium falling due after the 1st premium, during which grace period the policy shall continue in force.".

(ii) A policy which contains a cancellation provision may add, at the end of the above provision, "Subject to the right of the insurer to cancel in accordance with the cancellation provision hereof.".

(iii) A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision;

"Unless not less than 5 days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted.".

(D)(i) A provision as follows:

"REINSTATEMENT: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer, or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.".

(ii) The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age 50 or in the case of a policy issued after age 44, for at least 5 years from its date of issue.

(E)(i) A provision as follows:

"NOTICE OF CLAIM: Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at ..... (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.".

(ii) In a policy providing a loss-of-time benefit which may be payable for at least 2 years, an insurer may at its option insert the following between the 1st and 2nd sentences of the above provision:

"Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least 2 years, he shall, at least once in every 6 months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of 6 months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of 6 months preceding the date on which such notice is actually given.".

(F) A provision as follows:

"CLAIM FORMS: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made."

(G) A provision as follows:

"PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no

event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.".

(H) A provision as follows:

"TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid ..... (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.".

(I)(i) A provision as follows:

"PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.".

(ii) The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer:

"If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity up to an amount not exceeding $..... (insert an amount which shall not exceed $1,000), to any relative by blood or connection by marriage or domestic partnership of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

"Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.".

(J) A provision as follows:

"PHYSICAL EXAMINATIONS AND AUTOPSY: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.".

(K) A provision as follows:

"LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.".

(L)(i) A provision as follows:

"CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.".

(ii) The 1st clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.

(2) *Other provisions.* — Except as provided in paragraph (3) of this subsection, no such policy delivered or issued for delivery to any person in the District shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this paragraph; provided, however, that the insurer may, at its option, use

in lieu of any such provision a corresponding provision of different wording approved by the Commissioner which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this paragraph or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Commissioner may approve:

(A) A provision as follows:

"CHANGE OF OCCUPATION: If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess prorata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the official having supervision of insurance in the jurisdiction where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such jurisdiction prior to the occurrence of the loss or prior to the date of proof of change in occupation.".

(B) A provision as follows:

"MISSTATEMENT OF AGE: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.".

(C)(i) A provision as follows:

"OTHER INSURANCE IN THIS INSURER: If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for ..... (insert type of coverage or coverages) in excess of $..... (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate.".

(ii) Or, in lieu thereof: "Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies.".

(D)(i) A provision as follows:

"INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the 'like amount' of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.".

(ii) If the foregoing policy provision is included in a policy which also contains the next following policy provision there shall be added to the caption of the foregoing provision the phrase " — EXPENSE INCURRED BENEFITS". The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to

form by the Commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other jurisdiction of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the Commissioner. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workmen's compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no 3rd party liability coverage shall be included as "other valid coverage."

(E)(i) A provision as follows:

"INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense-incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined.".

(ii) If the foregoing policy provision is included in a policy which also contains the next preceding policy provision there shall be added to the caption of the foregoing provision the phrase " — OTHER BENEFITS". The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the Commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other jurisdiction of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the Commissioner. In the absence of such definition such term shall not include group insurance, or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workmen's compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no 3rd-party liability coverage shall be included as "other valid coverage."

(F)(i) A provision as follows:

"RELATION OF EARNINGS TO INSURANCE: If the total monthly amount of loss-of-time benefits promised for the same loss under all valid loss-of-time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of 2 years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such 2 years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of $200 or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time.".

(ii) The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age 50 or in the case of a policy issued after age 44, for at least 5 years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss-of-time coverage," approved as to form by the Commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other jurisdiction of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the Commissioner or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workmen's compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations;

(G) A provision as follows:

"UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.".

(H) A provision as follows:

"CANCELLATION: The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to his last address as shown by the records of the insurer, stating when, not less than 5 days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the official having supervision of insurance in the jurisdiction where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.".

(I) A provision as follows:

"CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its effective date, is in conflict with the statutes of the jurisdiction in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.".

(J) A provision as follows:

"ILLEGAL OCCUPATION: The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.".

(K) Repealed.

(3) *Inapplicable or inconsistent provisions.* — If any provision of this subsection is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy the insurer, with the approval of the Commissioner, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

(4) *Order.* — The provisions which are the subject of paragraphs (1) and (2) of this subsection, or any corresponding provisions which are used in lieu thereof in accordance with such paragraphs, shall be printed in the consecutive order of the provisions in such paragraphs or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered, or issued.

(5) *Third-party rights.* — The word "insured," as used in this section, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits, and rights provided therein.

(6) *Rules and regulations.* — The Council of the District of Columbia may make such reasonable rules and regulations concerning the procedure for the filing or submission of policies subject to this section as are necessary, proper or advisable to the administration of this section. This provision shall not abridge any other authority granted the Commissioner by law.

(d) *Conforming to statutory requirements.* —

(1) *Provisions not subject to requirements.* — Provisions not subject to requirements. No policy provision which is not subject to subsection (c) of this section shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary then the provisions thereof which are subject to this section.

(2) *Violations and conflicts.* — A policy delivered or issued for delivery to any person in the District in violation of this section shall be held valid but shall be construed as provided in this section. When any provision in a policy subject to this section is in conflict with any provision of this section, the rights, duties, and obligations of the insurer, the insured, and the beneficiary shall be governed by the provisions of this section.

(e) *Applications.* — (1) The insured shall not be bound by any statement made in an application for a policy unless a copy of such application is attached to or endorsed on the policy when issued as a part thereof. If any such policy delivered or issued for delivery to any person in the District shall be reinstated or renewed, and the insured or the beneficiary or assignee of such policy shall make written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall, within 15 days after the receipt of such request at its home office or any branch office of the insurer, deliver or mail to the person making such request, a copy of such application. If such copy shall not be so delivered or mailed, the insurer shall be precluded from introducing such application as evidence in any action or proceeding based upon or involving such policy or its reinstatement or renewal.

(2) No alteration of any written application for any such policy shall be made by any person other than the applicant without his written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

(3) The falsity of any statement in the application for any policy covered by this section may not bar the right to recovery thereunder unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer.

(f) *Waiver of insurer's rights.* — The acknowledgment by any insurer of the receipt of notice given under any policy covered by this section, or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the insurer in defense of any claim arising under such policy.

(g) *Limitations on coverage.* — If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

(h) *Exceptions.* — Except as provided in § 31–4724, nothing in this section shall apply to or affect:

(1) Repealed.

(2) Life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance as:

(A) Provide additional benefits in case of death or dismemberment or loss of sight by accident; or

(B) Operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall come to have a total and permanent disability, as defined by the contract or supplemental contract; provided, that no such supplemental contract shall be issued or delivered to any person in the District unless and until a copy of the form thereof has been submitted to and approved by the Commissioner under such reasonable rules and regulations as the Council of the District of Columbia shall make concerning the provisions in such contracts and their submission to and approval by him.

(June 19, 1934, 48 Stat. 1166, ch. 672, ch. V, § 12; July 12, 1950, 64 Stat. 335, ch. 457, § 3; July 16, 1953, 67 Stat. 162, ch. 196, § 1; Feb. 19, 1976, D.C. Law 1–46, § 2, 22 DCR 4680; Feb. 11, 1982, D.C. Law 4–66, § 2(a), 28 DCR 5040; Aug. 25, 1994, D.C. Law 10–158, § 2, 41 DCR 4881; Apr. 18, 1996, D.C. Law 11–110, § 36, 43 DCR 530; May 21, 1997, D.C. Law 11–268, § 10(j), 44 DCR 1730; Mar. 24, 1998, D.C. Law 12–81, § 23(d), 45 DCR 745; Mar. 8, 2007, D.C. Law 16–247, § 2, 54 DCR 620; Apr. 24, 2007, D.C. Law 16–305, § 43, 53 DCR 6198; Sept. 12, 2008, D.C. Law 17–231, § 28(c), 55 DCR 6758; Mar. 25, 2009, D.C. Law 17–353, § 199, 56 DCR 1117; Apr. 8, 2011, D.C. Law 18–360, § 504, 58 DCR 896.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 18–360, in subsec. (a), rewrote the last sentence which had read as follows: "The action of the Commissioner in this regard shall be subject to appeal and review in the form and manner prescribed in § 31–4327." ; and repealed subsec. (h)(1), which formerly read:

"(1) Any policy of group accident, group health, or group accident and health insurance; or"

Legislative History of Laws

For history of Law 18–360, see notes under § 31–2231.11.

SUBTITLE VII
PROPERTY AND RELATED INSURANCE.

Chapter 50A
Title Insurance Insurers.

Section	
31–5031.01.	Definitions.
31–5031.02.	Licensing needed to transact business.
31–5031.03.	Authorized activities of title insurers.
31–5031.04.	Limitations on powers.
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31–5031.06.	Single risk limit.
31–5031.07.	Admitted asset standards.
31–5031.08.	Reserves.
31–5031.09.	Liquidation, dissolution, or insolvency.
31–5031.10.	Restrictions on dividends.
31–5031.11.	Diversification requirement.
31–5031.13.	Duties of title insurers utilizing the services of title insurance producers.
31–5031.14.	Conditions for maintaining escrow and indemnity deposit accounts.
31–5031.15.	Prohibition of rebate and fee splitting.
31–5031.16.	Favored agent of title insurer.
31–5031.17.	Premium rate filings and standards.
31–5031.18.	Form filing.
31–5031.19.	Filing by rating bureaus.
31–5031.20.	Record retention requirements.
31–5031.21.	Penalties and liabilities.
31–5031.22.	Violations of Real Estate Settlement Procedures Act ("RESPA") .
31–5031.23.	Rules; orders.
31–5031.24.	Applicability; construction.

§ 31–5031.01. Definitions.

For the purposes of this chapter, the term:

(1) "Abstract of title" or "abstract" means a written history, synopsis, or summary of the recorded instruments affecting the title to real property.

(2) "Affiliate" means, with respect to a person, another person that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with the person.

(3) "Aggrieved party" means a lender, title insurer, consumer, or the District of Columbia, who shall have suffered economic harm as a result of matters insured under any fidelity coverage required under this chapter.

(4) "Attorney" means a person who holds a license to practice law in the District of Columbia.

(5) "Commissioner" means the Commissioner of the Department of Insurance, Securities, and Banking, or the Commissioner's representatives, or the commissioner, director, or superintendent of insurance in any other state.

(6) "Direct operations" means that portion of a title insurer's operations that is attributable to business written or conducted directly by an employee of:

(A) The title insurer;

(B) A title insurance producer owned by:

(i) The title insurer;

(ii) A parent entity owning the title insurer;

(iii) A holding entity owning the title insurer; or

(iv) A subsidiary of a parent or holding entity owning a title insurer.

(7) "Escrow" means written instruments, money, or other items deposited by one party with a depository, escrow agent, or escrowee for delivery to another party upon the performance of a specified condition or the happening of a certain event.

(8) "Escrow Officer" means a person who maintains an escrow or indemnified deposit account.

(9) "Escrow, settlement, or closing fee" means the consideration for supervising or handling the actual execution, delivery, or recording of transfer and lien documents and for disbursing funds.

(10) "Fire and Casualty Act" means Chapter 25 of this title.

(11) "Foreign title insurer" means any title insurer incorporated or organized under the laws of any other state of the United States or any other jurisdiction of the United States.

(12) "Indemnity" or "indemnity deposit" means funds or other property received by the title insurer as collateral to secure an indemnitor's obligation under an indemnity agreement pursuant to which the insurer is granted a perfected security interest in the collateral in exchange for agreeing to provide coverage in a title insurance policy for a specific title exception to coverage.

(13) "IRLA" means Chapter 13 of this title.

(14) "Net retained liability" means the total liability retained by a title insurer for a single risk, after taking into account any ceded liability and collateral, acceptable to the Commissioner, maintained by the insurer.

(15) "Non–U.S. title insurer" means any title insurer incorporated or organized under the laws of any foreign nation or any province or territory.

(16) "Person" means an individual, partnership, limited liability company, association, cooperative, corporation, trust, or other legal entity.

(17) "Personal property" means stock ownership in a cooperative housing association.

(18) "Qualified financial institution" means an institution that is:

(A) Organized or, in the case of a United States branch or agency office of a foreign banking organization, licensed under the laws of the United States or any state and has been granted authority to operate with fiduciary powers;

(B) Regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies;

(C) Insured by the appropriate federal entity; and

(D) Qualified under any additional rules established by the Commissioner.

(19) "Referral source" means any person, including an officer, director, or owner of more than 5% or more of the equity or capital of any person engaged in the District in the trade, business, occupation, or profession of:

(A) Buying or selling interests in real property;

(B) Making loans secured by interests in real property; or

(C) Acting as broker, agent, representative, or attorney of a person who buys or sells any interest in real property or who lends or borrows money with the interest as security.

(20) "Residential property" means real property located in the District of Columbia with one to 4 residential dwelling units in the same or appurtenant structure.

(21) "Subsidiary" means an affiliate controlled by a person, directly or indirectly, through one or more intermediaries.

(22) "Title insurance business" or "business of title insurance" means:

(A) Issuing as an insurer, or offering to issue as an insurer, a title insurance policy;

(B) Engaging in, or proposing to engage in, any of the following activities when conducted or performed in contemplation of or in conjunction with the issuance of a title insurance policy:

(i) Soliciting or negotiating the issuance of a title insurance policy;

(ii) Guaranteeing, warranting, or otherwise insuring the correctness of title searches for all instruments affecting titles to real property, any interest in real property, cooperative units, and proprietary leases, and for all liens or charges affecting the same;

(iii) Executing title insurance policies;

(iv) Effecting contracts of reinsurance; or

(v) Abstracting, searching, or examining titles;

(C) Guaranteeing, warranting, or insuring searches or examinations of title to real property or any interest in real property;

(D) Guaranteeing or warranting the status of title as to ownership of or liens on real property or personal property by any person other than the principals to the transaction;

(E) Doing, or holding oneself out to do, business substantially equivalent to any of the activities listed in this paragraph in a manner designed to evade the provisions of this chapter; or

(F) Matters insuring the correctness or marketability of title.

(23) "Title insurance commitment" means a preliminary report, commitment, or binder issued prior to the issuance of a title insurance policy containing the terms, conditions, exceptions, and any other matters incorporated by reference under which the title insurer is willing to issue its title insurance policy.

(24) "Title insurance policy" or "policy" means a contract insuring or indemnifying owners of, or other persons lawfully interested in, real or personal property or any interest in real or personal property, against loss or damage arising from any or all of the following conditions existing on or before the policy date and not excepted or excluded:

(A) Defects in, or liens or encumbrances on, the insured title;

(B) Unmarketability of the insured title;

(C) Invalidity, lack of priority, or unenforceability of liens or encumbrances on the stated property;

(D) Lack of legal right of access to the land;

(E) Unenforceability of rights in title to the land and other matters affecting the title to, or the right to the use and enjoyment of, the property; or

(F) Matters insuring the correctness or marketability of title.

(25)(A) "Title insurance producer" or "producer" means a person who is authorized to perform, on behalf of a title insurer, the following acts in conjunction with the issuance of a title insurance commitment or policy covering residential or personal property situated in the District of Columbia:

(i) Determining insurability and issuing title insurance commitments or policies, or both, based upon the performance or review of a search or abstract of title; and

(ii) Soliciting or negotiating title insurance business.

(B) The term "title insurance producer" or "producer" shall not include:

(i) A financial institution (and its employees) that does not solicit, procure, or negotiate title insurance contracts for compensation or conduct title insurance business;

(ii) An employee of an abstracting company;

(iii) A person whose activities in the District are limited to advertising, without the intent to solicit insurance in the District, through communications in printed publications or other forms of electronic mass media; provided, that the person does not sell, solicit, or negotiate insurance that would insure risks of persons residing in or located in, or activities to be performed in, the District;

(iv) A salaried full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or of the subsidiaries of the employer; provided, that the employee does not sell, solicit, or negotiate insurance, or receive a commission; or

(v) An employee of a title insurer; provided, that the employee's activities are not focused on transactions in the District of Columbia, his or her primary responsibilities cover multiple states, and his or her involvement in transactions is to coordinate with title insurance producers licensed in the District of Columbia who conduct title insurance business.

(26) "Title insurer" or "insurer" means a company organized under laws of the District of Columbia for the purpose of transacting the business of title insurance and any foreign or non-U.S. title insurer licensed in the District of Columbia to transact the business of title insurance.

(27) "Title plant" means a set of records consisting of documents, maps, surveys, or entries affecting title to real property or any interest in or encumbrance on the property, which have been filed or recorded in the jurisdiction for which the title plant is established or maintained.

(28) "Underwrite" means to accept or reject, or have the authority to accept or reject, risk on behalf of a title insurer.

(Sept. 24, 2010, D.C. Law 18–223, § 2142, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2142 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

Law 18–223, the "Fiscal Year 2011 Budget Support Act of 2010", was introduced in Council and assigned Bill No. 18–731, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on May 26, 2010, and June 15, 2010, respectively. Signed by the Mayor on July 2, 2010, it was assigned Act No. 18–462 and transmitted to both Houses of Congress for its review. D.C. Law 18–223 became effective on September 24, 2010.

Miscellaneous Notes

Short title: Section 2141 of D.C. Law 18–223 provided that subtitle M of title II of the act may be cited as the "Title Insurance Insurer Act of 2010".

§ 31–5031.02. Licensing needed to transact business.

No person, other than a domestic, foreign, or non-U.S. title insurer organized on the stock plan and licensed under Chapter 25 of this title, shall issue a title insurance policy or otherwise transact the business of title insurance in the District.

(Sept. 24, 2010, D.C. Law 18–223, § 2143, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2143 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5031.01.

§ 31–5031.03. Authorized activities of title insurers.

Subject to the exceptions and restrictions contained in this chapter, a title insurer may do any of the following:

(1) Engage in the business of writing title insurance directly or through title insurance producers appointed for the purpose of issuing policies of title insurance;

(2) Reinsure title insurance policies;

(3) Unless prohibited by the Commissioner, perform ancillary activities, including examining titles to real property and any interest in real or personal property and procuring and furnishing related information and information about relevant personal property, when not in contemplation of, or in conjunction with, the issuance of a title insurance policy; and

(4) Maintain or perform escrow, indemnity, or settlement services.

(Sept. 24, 2010, D.C. Law 18–223, § 2144, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2144 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5031.01.

§ 31–5031.04. Limitations on powers.

(a) An insurer that transacts any class, type, or kind of business other than title insurance business shall not be eligible for the issuance or renewal of a license to transact the business of title insurance in the District of Columbia and shall not transact title insurance business.

(b) A title insurer shall not engage in the business of guaranteeing payment of the principal of, or the interest on, bonds or mortgages.

(c)(1) Notwithstanding subsection (a) of this section, and to the extent such coverage is lawful within the District, a title insurer may issue closing or settlement protection to a proposed insured upon request if the title insurer issues a preliminary report, binder, or title insurance policy. The closing or settlement protection shall conform to the terms of coverage and form of instrument as required by the Commissioner and may indemnify a proposed insured solely against loss of settlement funds only because of the following acts of a title insurer's named title insurance producer:

(A) Theft of settlement funds in connection with the closing to the extent that the theft relates to the status of the title to that interest in land or to the validity, enforceability, and priority of the lien of the mortgage on that interest in land; and

(B) Failure to comply with the written closing instructions by the proposed insured when agreed to by the title insurance producer, to the extent that they relate to the status of the title to that interest in land or the validity, enforceability, and priority of the lien of the mortgage on that interest in land.

(2) The Commissioner may promulgate by rule pursuant to § 31–5031.23, or approve, a required charge for providing the coverage.

(3) The charge for issuance of a closing or settlement protection letter in a residential property transaction indemnifying a seller of an interest in real property, a refinancing borrower, or a buyer who does not purchase title insurance shall be not less than $50.

(4) Except as provided under this chapter, a title insurer shall not provide any other coverage which purports to indemnify against improper acts or omissions of a person with regard to escrow, settlement, or closing services.

(5) The form of closing protection letter used by a title insurer and rates shall be filed with the Commissioner as provided by § 31–5031.18(b)(3).

(Sept. 24, 2010, D.C. Law 18–223, § 2145, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2145 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5031.01.

§ 31–5031.05. Minimum capital and surplus requirements.

Before being licensed to do an insurance business in the District, a title insurer shall establish and maintain a minimum paid-in capital of not less than $500,000 and paid-in initial surplus of at least $500,000, for a total minimum capital and surplus total of at least $1 million.

(Sept. 24, 2010, D.C. Law 18–223, § 2146, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2146 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5031.01.

§ 31–5031.06. Single risk limit.

(a) The net retained liability of a title insurer for a single risk in regard to property, whether assumed directly or as reinsurance, shall not exceed the aggregate of 50% of surplus as regards policyholders, plus the statutory premium reserve less the company's investment in title plants, all as shown in the most recent annual statement of the insurer on file with the Commissioner.

(b) For the purposes of this chapter:

(1) A single risk shall be the insured amount of any title insurance policy; provided, that, if 2 or more title insurance policies are issued simultaneously covering different estates in the same real property, a single risk shall be the sum of the insured amounts of all the title insurance policies.

(2) A policy under which a claim payment reduces the amount of insurance under one or more other title insurance policies shall be included in computing the single risk sum only to the extent that its amount exceeds the aggregate amount of the policy or policies whose amount of insurance is reduced.

(Sept. 24, 2010, D.C. Law 18–223, § 2147, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2147 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5031.01.

§ 31–5031.07. Admitted asset standards.

In determining the financial condition of a domestic title insurer doing business under this chapter, the general investment provisions of the Chapter 13A of this title shall apply; provided, that:

(1) An investment in a title plant or plants in an amount equal to the actual cost shall be allowed as an admitted asset for title insurers; and

(2) The aggregate amount of the investment shall not exceed the lesser of 20% of admitted assets or 40% of surplus to policyholders, as shown on the most recent annual statement of the title insurer on file with the Commissioner.

(Sept. 24, 2010, D.C. Law 18–223, § 2148, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2148 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5031.01.

§ 31–5031.08. Reserves.

(a) In determining the financial condition of a title insurer doing business under this chapter, the general provisions of the acts relating to insurance which are codified in this title requiring the establishment of reserves sufficient to cover all known and unknown liabilities, including allocated and unallocated loss adjustment expense, shall apply; provided, that a domestic title insurer shall establish and maintain:

(1) A known claim reserve in an amount estimated to be sufficient to cover all unpaid losses, claims, and allocated loss adjustment expenses arising under title insurance policies, guaranteed certificates of title, guaranteed searches, and guaranteed abstracts of title, and all unpaid losses, claims, and allocated loss adjustment expenses for which the title insurer may be liable, and for which the insurer has received notice by or on behalf of the insured, holder of a guarantee or escrow, or indemnity depositor; and

(2) A statutory or unearned premium reserve consisting of:

(A) The amount of statutory or unearned premium reserve required by the laws of the domiciliary state of the insurer if the insurer is a foreign or non-U.S.title insurer; or

(B) If the insurer is a domestic insurer of the District of Columbia:

(i) The amount of the statutory or unearned premium or reinsurance reserve on January 1, 2011, which balance shall be released in accordance with the law in effect at the time such sums were added to the reserve; and

(ii) Out of total charges for policies of title insurance written or assumed commencing with January 1, 2011, and until December 31, 2011, a title insurer shall add to, and set aside in, the reserve an amount equal to 8% of the sum of the following items set forth in the title insurer's most recent annual statement on file with the Commissioner:

(I) Direct premiums written;

(II) Escrow and settlement service fees;

(III) Other title fees and service charges, including fees for closing protection letters; and

(IV) Premiums for reinsurance assumed, less premiums for reinsurance ceded during year.

(b) Additions to the reserve after January 1, 2011, shall be, made out of total charges for title insurance policies and guarantees written, equal to the sum of the following items, as set forth in the title insurer's most recent annual statement on file with the Commissioner:

(1) For each title insurance policy on a single risk written or assumed after January 1, 2011, $0.36 per $1,000 of net retained liability for policies under $500,000 and $0.16 per $1,000 of net retained liability for policies of $500,000 or greater; and

(2) Eight percent of escrow, settlement, and closing fees collected in contemplation of the issuance of title insurance policies or guarantees.

(c) The aggregate of the amounts set aside in the reserve in any calendar year pursuant to subsections (a)(2)(B)(ii) and (b) of this section shall be released from the reserve and restored to net profits over a period of 20 years pursuant to the following formula:

(1) Thirty–five percent of the aggregate sum on July 1 of the year next succeeding the year of addition;

(2) Fifteen percent of the aggregate sum on July 1 of each of the succeeding 2 years;

(3) Ten percent of the aggregate sum on July 1 of the next succeeding year;

(4) Three percent of the aggregate sum on July 1 of each of the next 3 succeeding years;

(5) Two percent of the aggregate sum on July 1 of each of the next 3 succeeding years; and

(6) One percent of the aggregate sum on July 1 of each of the next succeeding 10 years.

(d) A supplemental reserve shall be established consisting of any other reserves necessary, when taken in combination with the reserves required by this section, to cover the company's liabilities with respect to all losses, claims, and loss-adjusted expenses.

(e) A title insurer subject to the provisions of this chapter shall file with its annual statement required under Chapter 19 of this title a certification by a member in good

standing of the American Academy of Actuaries. The actuarial certification required of a title insurer shall conform to the National Association of Insurance Commissioners' annual statement instructions for title insurers.

(Sept. 24, 2010, D.C. Law 18–223, § 2149, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2149 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5031.01.

§ 31–5031.09. Liquidation, dissolution, or insolvency.

(a) Except as otherwise provided in this section, the IRLA shall apply to all domestic title insurers subject to this chapter. In applying the provisions of the IRLA, the court shall consider the unique aspects of title insurance and shall have broad authority to fashion relief that provides for the maximum protection of the title insurance policyholders.

(b) Indemnity and escrow funds held by or on behalf of the title insurer shall not become general assets and shall be administered as secured creditor claims as provided in the IRLA.

(c) Title insurance policies issued by a domestic title insurer that are in force at the time an order of liquidation is entered shall not be canceled except upon a showing to the court of good cause by the liquidator. The determination of good cause shall be within the discretion of the court. In making this determination, the court shall consider the unique aspects of title insurance and all other relevant circumstances.

(d) The court may set appropriate dates that potential claimants shall file their claims with the liquidator as to a domestic title insurer. The court may set different dates for claims based upon the title insurance policy than for all other claims. In setting dates, the court shall consider the unique aspects of title insurance and all other relevant circumstances.

(e) As of the date of the order of insolvency or liquidation, all premiums paid, due, or to become due under policies of the domestic title insurers shall be fully earned. It shall be the obligation of agents, insureds, or representatives of the title insurer to pay fully earned premium to the liquidator or rehabilitator.

(Sept. 24, 2010, D.C. Law 18–223, § 2150, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2150 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5031.01.

§ 31–5031.10. Restrictions on dividends.

A domestic title insurer shall only declare or distribute a dividend to shareholders without the prior written approval of the Commissioner as would be permitted under § 31–706, for insurers other than life insurers.

(Sept. 24, 2010, D.C. Law 18–223, § 2151, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2151 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5031.01.

§ 31–5031.11. Diversification requirement.

(a) Without the prior written approval of the Commissioner, a domestic title insurer shall not accept:

(1) Additional business from a title insurance agent that is not an affiliated company with the insurer if, when added to other business written through the title insurance agent during the same calendar year, that agent's aggregate premiums written on behalf of the title insurer will exceed 20% of the title insurer's gross premiums written during the prior calendar year, as shown on the title insurer's most recent annual statement on file with the Commissioner; or

(2)(A) Additional direct operations business from a single source if, when added to other direct operations business from the single source during the same calendar year, the aggregate premiums written on the direct operations business of the single source will exceed 20% of the title insurer's gross premiums written during the prior calendar year as shown on the title insurers most recent annual statement on file with the Commissioner.

(B) For purposes of this paragraph, the term "single source" means a person that refers business to the title insurer and any other person that controls, is controlled by, or is under common control with, that person.

(b) In determining whether prior approval may be given, the Commissioner shall consider:

(1) The potential that the acceptance of more business from the title insurance producer or source may adversely affect the financial solidity of the title insurer;

(2) The availability of competing title agents or additional sources in the territories in which the title insurer accepts risks;

(3) The number of years that the title insurer has been in business;

(4) Reinsurance arrangements mitigating the concentration of business from the agent or source;

(5) The comparative profitability of the agent's or source's book of business;

(6) The degree of oversight of the agent's operations exercised by the title insurer; and

(7) Any other circumstances considered by the Commissioner to be appropriate.

(Sept. 24, 2010, D.C. Law 18–223, § 2152, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2152 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5031.01.

§ 31–5031.12 Direct operations and policyholder treatment.

(a) If a title insurance commitment includes an offer to issue an owner's policy covering the resale of owner-occupied residential property, the title insurance commitment shall be furnished to the purchaser-mortgagor or its representative as soon as reasonably possible prior to closing. If the report cannot be delivered prior to or at closing, the title insurer shall document the reasons for the delay. The title insurance commitment furnished to the purchaser-mortgagor shall incorporate the following statement on the 1st page in bold type:

"Please read the exceptions and the terms shown or referred to herein carefully. The exceptions are meant to provide you with notice of matters which are not covered under the terms of the title insurance policy and should be carefully considered.

It is important to note that this form is not a written representation as to the condition of title and may not list all liens, defects, and encumbrances affecting title to the land."

(b)(1) A title insurer issuing a lender's title insurance policy in conjunction with a mortgage loan made simultaneously with the purchase of all or part of the owner-occupied residential property securing the loan, if no owner's title insurance policy has been requested, shall give written notice, on a form prescribed or approved by the Commissioner, to the purchaser-mortgagor at the time the title insurance commitment is prepared. The notice shall explain:

(A) A lender's title insurance policy is to be issued protecting the mortgage-lender;

(B) The policy does not provide title insurance protection to the purchaser-mortgagor as the owner of the property being purchased;

(C) What a title policy insures against and what possible exposures exist for the purchaser-mortgagor that could be insured against through the purchase of an owner's policy; and

(D) The purchaser-mortgagor may obtain an owner's title insurance policy protecting the property owner at a specified cost or approximate cost, if the proposed coverages or amount of insurance is not then known.

(2) A copy of the notice, signed by the purchaser-mortgagor, shall be retained in the relevant underwriting file at least 5 years after the effective date of the policy.

(Sept. 24, 2010, D.C. Law 18–223, § 2153, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2153 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5031.01.

§ 31–5031.13. Duties of title insurers utilizing the services of title insurance producers.

(a) The title insurer shall not accept business from a title insurance producer unless there is in force a written contract between the parties which sets forth the responsibilities of each party and, if both parties share responsibility for a particular function, specifies the division of responsibilities.

(b) For each title insurance producer under contract with the insurer, the title insurer shall have on file a statement of financial condition of each title insurance producer as of the end of the previous calendar year setting forth an income statement of business done during the preceding year and a balance sheet showing the condition of its affairs as of the prior December 31st certified by the title insurance producer as being a true and accurate representation of the producer's financial condition.

(c) The title insurer shall, at least annually, conduct an on-site review, or a review conducted electronically that would accomplish the functional equivalent of the same, of the underwriting, claims, and escrow practices of the title insurance producer which shall include a review of the producer's policy blank inventory and processing operations. If the title insurance producer does not maintain separate bank or trust accounts for each title insurer it represents, the title insurer shall verify that the funds held on its behalf are reasonably ascertainable from the books of account and records of the title insurance producer.

(d) Within 30 days after executing or terminating a contract with a title insurance producer, the title insurer shall provide written notification of the appointment or termination and the reason for termination to the Commissioner. Notices of appointment of a title insurance producer shall be made on a form promulgated by the Commissioner.

(e) A domestic title insurer shall not appoint to its board of directors an officer, director, employee, controlling shareholder, or any title insurance agent who wrote 1% or more of the title insurer's direct premiums written during the previous calendar year as shown on the title insurer's most recent annual statement on file with the Commissioner. This subsection shall not apply to relationships governed by Chapter 7 of this title.

(f) The title insurer shall maintain an inventory of all policy forms or policy numbers allocated to each title insurance producer.

(g) The title insurer shall have on file proof that the title insurance producer is licensed in the District.

(h) The title insurer shall establish the underwriting guidelines and, if applicable, limitations on title claims settlement authority to be incorporated into contracts with its title insurance producers.

(Sept. 24, 2010, D.C. Law 18–223, § 2154, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2154 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5031.01.

§ 31–5031.14. Conditions for maintaining escrow and indemnity deposit accounts.

(a) A title insurer may operate as an escrow, indemnity, settlement, or closing agent, if:

(1) All funds deposited with the title insurer in connection with any escrow, settlement, closing, or indemnity deposit shall be submitted for collection to or deposited in a fiduciary trust account in a qualified financial institution no later than the close of the next business day in accordance with the following requirements:

(A) The funds shall be the property of the person entitled to them under the provisions of the escrow, settlement, indemnity deposit, or closing agreement and shall be segregated for each depository by escrow, settlement, indemnity deposit, or closing in the records of the title insurer in a manner that permits the funds to be identified on an individual basis; and

(B) The funds shall be applied only in accordance with the terms of the individual instructions or agreements under which the funds were accepted.

(b) Funds held in an escrow account shall be disbursed only pursuant to a written instruction or agreement specifying how and to whom the funds may be disbursed.

(c) Funds held in an indemnity deposit account shall be disbursed only pursuant to a written agreement specifying:

(1) What actions the indemnitor shall take to satisfy his or her obligation under the agreement;

(2) The duties of the title insurer with respect to disposition of the funds held, including a requirement to maintain evidence of the disposition of the title exception before any balance may be paid over to the depositing party or his or her designee; and

(3) Any other provisions the Commissioner may require.

(d) Any interest received on funds deposited in connection with any escrow, settlement, indemnity deposit, or closing shall be paid, net of administrative costs, to the depositing party, unless the depositor's instructions for the funds or a governing law provides otherwise.

(e) Disbursements may be made out of an escrow, settlement, or closing account only if deposits in amounts at least equal to the disbursement have first been made directly relating to the transaction disbursed against and if the deposits are in one of the following forms:

(1) Cash;

(2) Wire transfers such that the funds are unconditionally received by the title insurer or the insurer's depository;

(3) Checks, drafts, negotiable orders of withdrawal, money orders, and any other item that has been finally paid before any disbursements; provided, that a title insurer may accept a check in an amount not to exceed $3,000 that has not been finally paid before any disbursements;

(4) A depository check, including a certified check, governed by the provisions of the Expedited Funds Availability Act, approved August 10, 1987 (101 Stat. 635; 12 U.S.C. § 4001 *et seq.*); or

(5) Credit transfers through the Automated Clearing House which have been deemed available by the depository institution receiving the credits transfers and conform to the operating rules set forth by the National Automated Clearing House Association.

(f) This chapter shall not:

(1) Prohibit the recording of documents prior to the time funds are available for disbursement with respect to a transaction; provided, that all parties consent to the transaction in writing; or

(2) Amend, alter, or supersede other sections of this chapter, or the laws of the District of Columbia or the United States, regarding an escrow holder's duties and obligations.

(g) The Commissioner may prescribe a standard agreement for escrow, settlement, closing, or indemnity deposit funds.

(Sept. 24, 2010, D.C. Law 18–223, § 2155, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2155 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5031.01.

§ 31–5031.15. Prohibition of rebate and fee splitting.

A title insurer or other person shall not give or receive, directly or indirectly, any consideration for the referral of title insurance business or escrow or other service provided by a title insurer.

(Sept. 24, 2010, D.C. Law 18–223, § 2156, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2156 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5031.01.

§ 31–5031.16. Favored agent of title insurer.

A title insurer shall not participate in any transaction in which it knows that a title insurance producer or other person requires, directly or indirectly, or through any trustee, director, officer, agent, employee, or affiliate, as a condition precedent to selling or furnishing any other person a loan, or loan extension, credit, sale, property, contract, lease, or service, that the other person shall place a title insurance policy of any kind with the title insurer or through a particular title insurance agent.

(Sept. 24, 2010, D.C. Law 18–223, § 2157, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2157 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5031.01.

§ 31–5031.17. Premium rate filings and standards.

(a) A title insurer or title insurance producer may charge any rates regulated by the District of Columbia after January 1, 2011; provided, that in accordance with the premium rate schedule and manual filed by the title insurer with and approved by the Commissioner in accordance with applicable law and rules governing rate filings. The Commissioner may provide, by rule, for interim use of premium rate schedules in effect prior to January 1, 2011.

(b) The Commissioner may establish rules, including rules providing statistical plans, for use by all title insurers and title insurance producers in the recording and reporting of revenue, loss, and expense experience in such form and detail as is necessary to aid him or her in the establishment of rates and fees.

(c) The Commissioner may require that the information provided under this section be verified by oath of the insurer's or title insurance producer's president or vice president or secretary or actuary, as applicable. The Commissioner may further require that the information required under this section be subject to an audit conducted by an independent

certified public accountant. The Commissioner may establish a minimum threshold level at which an audit would be required.

(d) Information filed with the Commissioner relating to the experience of a particular producer shall be kept confidential, subject to subchapter II of Chapter 5 of Title 2.

(Sept. 24, 2010, D.C. Law 18–223, § 2158, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2158 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5031.01.

§ 31–5031.18. Form filing.

(a) A title insurer or authorized rate service organization shall not deliver, issue for delivery, or permit any of its authorized title insurance agents to deliver in the District, any form, in connection with title insurance written, unless it has been filed with the Commissioner and approved by the Commissioner or 30 days have elapsed and it has not been disapproved as misleading or in violation of public policy.

(b) Forms covered by this section shall include:

(1) Title insurance policies, including standard form endorsements;

(2) Title insurance commitments issued prior to the issuance of a title insurance policy; and

(3) Closing protection letters.

(c) After notice and opportunity to be heard are given to the insurer or rate service organization which submitted a form for approval, the Commissioner may withdraw approval of the form on finding that the use of the form is contrary to the legal requirements applicable at the time of withdrawal. The effective date of withdrawal of approval shall not be less than 90 days after notice of withdrawal is given.

(d) An approved policy form or endorsement providing coverage for which no identifiable premium is assessed may be incorporated into every applicable title insurance policy. The insurer shall disclose any additional coverage to the insured. The provisions of this section shall not operate to eliminate any underwriting standard of conditions relating to the approved policy forms or endorsements.

(e) Any term or condition related to an insurance coverage provided by an approved title insurance policy or any exception to the coverage, except those ascertained from a search and examination of records relating to a title or inspection or survey of a property to be insured, shall only be included in the policy after the term, condition, or exception has been filed with the Commissioner and approved.

(Sept. 24, 2010, D.C. Law 18–223, § 2159, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2159 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5031.01.

§ 31–5031.19. Filing by rating bureaus.

(a) A title insurer may satisfy its obligation to file premium rates, rating manuals, and forms as required by this chapter if:

(1) It becomes a member of, or a subscriber to, a rate service organization, organized and licensed under the provisions of acts relating to insurance which are codified in this title;

(2) The rate service organization makes the filings; and

(3) It authorizes the Commissioner in writing to accept the filings on the title insurer's behalf.

(b) This chapter shall not:

(1) Require any title insurer to become a member of, or a subscriber to, any rate service organization; and

(2) Prohibit the filing of deviations from rate service organization filings by any member or subscriber.

(Sept. 24, 2010, D.C. Law 18–223, § 2160, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2160 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5031.01.

§ 31–5031.20. Record retention requirements.

Evidence of the examination of title and determination of insurability for business written by a title insurer or title insurance producer and records relating to escrow and indemnity deposits shall be preserved and retained by the insurer or agent for as long as appropriate to the circumstances but not less than 3 years after the title insurance policy has been issued or 3 years after the escrow or indemnity deposit account has been closed. This section shall not apply to a title insurer acting as coinsurer if one of the other coinsurers has complied with this section.

(Sept. 24, 2010, D.C. Law 18–223, § 2161, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2161 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5031.01.

§ 31–5031.21. Penalties and liabilities.

(a) If the Commissioner determines that the title insurer or any other person has violated this chapter, or any rule or order promulgated under this chapter, after notice and opportunity to be heard, the Commissioner may order:

(1) A penalty not exceeding $2,500 for the 1st violation;

(2) A penalty not exceeding $5,000 for each successive violation; and

(3) Revocation or suspension of the title insurer's license.

(b) This section shall affect the right of the Commissioner to impose any other penalties provided for in any acts relating to insurance which are codified in this title.

(Sept. 24, 2010, D.C. Law 18–223, § 2162, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2162 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5031.01.

§ 31–5031.22. Violations of Real Estate Settlement Procedures Act ("RESPA").

The Commissioner or Attorney General may bring an action in a court of competent jurisdiction to enjoin or seek remedies for violations of the Real Estate Settlement Procedures Act of 1974, approved December 23, 1974 (88 Stat. 1724; 12 U.S.C. § 2601 *et seq.*).

(Sept. 24, 2010, D.C. Law 18–223, § 2163, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2163 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5031.01.

§ 31–5031.23. Rules; orders.

(a) The Commissioner, through the Mayor, pursuant to subchapter I of Chapter 5 of Title 2, may issue rules to implement the provisions of this chapter.

(b) The Commissioner may issue orders to implement the provisions of this chapter.

(Sept. 24, 2010, D.C. Law 18–223, § 2164, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2164 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5031.01.

§ 31–5031.24. Applicability; construction.

(a) This chapter shall:

(1) Apply to all persons engaged in the business of title insurance in the District; and

(2) Supplement the provisions of Chapter 25 of this title.

(b) This chapter shall not:

(1) Except as otherwise provided, limit the application of any acts relating to insurance which are codified in this title; or

(2) Limit or restrict the rights of policyholders, claimants, and creditors.

(c) If there is a conflict between a provision of this chapter and any provision in an act relating to insurance which is codified in this title, including Chapter 25 of this title, this chapter shall apply.

(d) This chapter shall apply as of January 1, 2011 and to all transactions entered into after January 1, 2011.

(Sept. 24, 2010, D.C. Law 18–223, § 2165, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2165 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5031.01.

Chapter 50B

Title Insurance Producers.

Section	
31–5041.01.	Definitions.
31–5041.02.	Licensing requirements.
31–5041.03.	Examination of operation of title insurance producers.
31–5041.04.	Record-retention requirements.
31–5041.05.	Policyholder treatment.
31–5041.06.	Conditions for providing escrow, settlement, closing, and indemnity deposit services.
31–5041.07.	Prohibition of rebate and fee splitting.
31–5041.08.	Underwriting contract required with title insurer.
31–5041.09.	Penalties and liabilities.
31–5041.10.	Violations of the Real Estate Settlement Procedures Act.
31–5041.11.	Rules.
31–5041.12.	Applicability; construction.

§ 31–5041.01. Definitions.

(a) For the purpose of this chapter, the term:

(1) "Abstract of title" means a written history, synopsis, or summary of the recorded instruments affecting a title to real property.

(2) "Affiliate" means, with respect to a person, another person that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with the person.

(3) "Aggrieved party" means a lender, title insurer, consumer, or the District of Columbia, who shall have suffered economic harm as a result of matters insured under any fidelity coverage required under this chapter.

(4) "Attorney" means a person who is admitted to practice law in the District of Columbia.

(5) "Commissioner" means the Commissioner of the Department of Insurance, Securities, and Banking.

(6) "Escrow" means written instruments, money, or other items deposited by a party with a depository, escrow producer, or escrowee for delivery to another party upon the performance of a specified condition or the happening of a certain event.

(7) "Escrow Officer" means a person who maintains an escrow or indemnified deposit account.

(8) "Indemnity" or "indemnity deposit" means funds or other property received by the title insurer as collateral to secure an indemnitor's obligation under an indemnity agreement pursuant to which the insurer is granted a perfected security interest in the collateral in exchange for agreeing to provide coverage in a title insurance policy for a specific title exception to coverage.

(9) "Person" means an individual, partnership, limited liability company, association, cooperative, corporation, trust, or other legal entity.

(10) "Personal property" means stock ownership in a cooperative housing association.

(11) "Producer Licensing Act" means Chapter 11A of this title.

(12) "Qualified financial institution" means an institution that is:

(A) Organized or, in the case of a United States branch or agency office of a non-U.S. banking organization, licensed under the laws of the United States, a state, the District of Columbia, or another jurisdiction of the United States and granted authority to operate with fiduciary powers;

(B) Regulated, supervised, and examined by an authority of the United States, a state, the District of Columbia, or another jurisdiction of the United States having regulatory authority over banks and trust companies;

(C) Insured by the appropriate federal entity; and

(D) Qualified under any additional rules established by the Commissioner.

(13) "RESPA" means the Real Estate Settlement Procedures Act of 1974, approved December 22, 1974 (88 Stat. 1724; 12 U.S.C. § 2601 *et seq.*).

(14) "Residential property" means real property located in the District of Columbia with one to 4 residential dwelling units in the same or appurtenant structure.

(15) "Subsidiary" means an affiliate controlled by a person, directly or indirectly, through one or more intermediaries.

(16) "Title insurance business" or "business of title insurance" means:

(A) Issuing as an insurer, or offering to issue as an insurer, a title insurance policy;

(B) Engaging in, or proposing to engage in, any of the following activities when conducted or performed in contemplation of or in conjunction with the issuance of a title insurance policy:

(i) Soliciting or negotiating the issuance of a title insurance policy;

(ii) Guaranteeing, warranting, or otherwise insuring the correctness of title searches for all instruments affecting titles to real property, any interest in real property, cooperative units, and proprietary leases, and for all liens or charges affecting the same;

(iii) Executing title insurance policies;

(iv) Effecting contracts of reinsurance; or

(v) Abstracting, searching, or examining titles;

(C) Guaranteeing, warranting; or insuring searches or examinations of title to real property or any interest in real property;

(D) Guaranteeing or warranting the status of title as to ownership of or liens on real property or personal property by any person other than the principals to the transaction;

(E) Doing, or holding oneself out to do, business substantially equivalent to any of the activities listed in this paragraph in a manner designed to evade the provisions of this chapter; or

(F) Matters insuring the correctness or marketability of title.

(17) "Title insurance commitment" means a preliminary report or binder issued prior to the issuance of a title insurance policy containing the terms, conditions, exceptions, and any other matters under which the title insurer is willing to issue its title insurance policy.

(18) "Title insurance policy" means a contract insuring or indemnifying owners of, or other persons lawfully interested in, real or personal property or an interest in real or personal property against loss or damage arising from any of the following conditions existing on or before the policy date and not expressly excepted or excluded from coverage:

(A) Defects in, or liens or encumbrances on, the insured title;

(B) Unmarketability of the insured title;

(C) Invalidity, lack of priority, or unenforceability of liens or encumbrances on the property;

(D) Lack of legal right of access to the property; or

(E) Unenforceability of rights in title to the property and other matters affecting the title to, or right to use and enjoyment of, the property.

(19)(A) "Title insurance producer" or "producer" means a person who is authorized to perform, on behalf of a title insurer, the following acts in conjunction with the issuance of a title insurance commitment or policy covering residential or personal property situated in the District of Columbia:

(i) Determining insurability and issuing title insurance commitments or policies, or both, based upon the performance or review of a search or abstract of title; and

(ii) Soliciting or negotiating title insurance business.

(B) The term "title insurance producer" or "producer" shall not include:

(i) A financial institution (and its employees) that does not solicit, procure, or negotiate title insurance contracts for compensation or conduct title insurance business;

(ii) An employee of an abstracting company;

(iii) A person whose activities in the District are limited to advertising, without the intent to solicit insurance in the District, through communications in printed publications or other forms of electronic mass media; provided, that the person does not sell, solicit, or negotiate insurance that would insure risks of persons residing in or located in, or activities to be performed, in the District;

(iv) A salaried full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or of the subsidiaries of the employer; provided, that the employee does not sell, solicit, or negotiate insurance, or receive a commission;

(v) An employee of a title insurer; provided, that the employee's activities are not focused on transactions in the District of Columbia, his or her primary responsibilities cover multiple states, and his or her involvement in transactions is to coordinate with title insurance producers licensed in the District of Columbia who conduct title insurance business.

(20) "Title insurer" or "insurer" means a company organized under laws of this state for the purpose of transacting the business of title insurance and any foreign or non-U.S. title insurer licensed in the District to transact the business of title insurance.

(21) "Underwrite" means to accept or reject, or have the authority to accept or reject, risk on behalf of a title insurer.

(Sept. 24, 2010, D.C. Law 18–223, § 2122, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2122 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

Law 18–223, the "Fiscal Year 2011 Budget Support Act of 2010", was introduced in Council and assigned Bill No. 18–731, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on May 26, 2010, and June 15, 2010, respectively. Signed by the Mayor on July 2, 2010, it was assigned Act No. 18–462 and transmitted to both Houses of Congress for its review. D.C. Law 18–223 became effective on September 24, 2010.

Miscellaneous Notes

Short title: Section 2121 of D.C. Law 18–223 provided that subtitle L of title II of the act may be cited as the "Title Insurance Producer Act of 2010".

§ 31–5041.02. Licensing requirements.

(a) A person shall not act in the capacity of a title insurance producer and a title insurer shall not contract with any person to act in the capacity of a title insurance producer with respect to risks located in the District unless the person is licensed as a title insurance producer in the District of Columbia in accordance with this chapter.

(b)(1) A title insurance producer licensed in the District shall:

(A) Disclose on all correspondence that the producer is acting as an appointed producer for a particular named underwriter;

(B) Exclude or eliminate the word "insurer" or "underwriter" or similar term from its agency's name; and

(C) Provide, in a timely fashion, each title insurer with which it places business any information the title insurer reasonably requests to comply with reporting requirements of the Commissioner.

(2) A title insurance producer operating in the District of Columbia licensed in the District of Columbia on January 1, 2011, shall have 180 days after January 1, 2011, to comply with the requirements of this subsection.

(c)(1) The Commissioner shall require the title insurance producer to maintain the following coverages for the benefit of the title insurer in amounts commensurate with the producer's average exposure, under terms and conditions, and from insurers, acceptable to the Commissioner:

(A) An errors and omission policy which includes coverage for a title insurance producer's delegation of any title insurance producer functions in an amount of not less than $500,000; and

(B) Fidelity coverage, if the title insurance producer handles escrow or indemnity deposits, in an amount of not less than $250,000 against which any aggrieved party may assert a claim.

(2) The Commissioner may promulgate rules specifying acceptable alternatives to the preceding insurance requirements. The availability of closing or settlement protection shall not be an acceptable alternative to the requirements of this subsection.

(d) If the title insurance producer delegates the title search to a third party, such as an abstract company, the title insurance producer shall exercise the appropriate diligence, in good faith, to determine that the third party is covered by or maintains the errors and omissions coverage required by subsection (c) of this section.

(e) All funds collected pursuant to this section shall be deposited into the Securities and Banking Regulatory Trust Fund established by § 31–107(b–2).

(Sept. 24, 2010, D.C. Law 18–223, § 2123, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2123 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5041.01.

§ 31–5041.03. Examination of operation of title insurance producers.

(a) The Commissioner, during normal business hours, may examine, audit, and inspect any and all books and records required and maintained by a title insurance producer; provided, that trust accounts maintained by attorneys shall be subject to any privilege permitted by law and properly asserted.

(b) The Commissioner may require that the information provided under this section be verified by oath of the title insurance producer or an officer, employee, or accountant of the title insurance producer.

(Sept. 24, 2010, D.C. Law 18–223, § 2124, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2124 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5041.01.

§ 31–5041.04. Record-retention requirements.

A title insurance producer shall maintain sufficient records of its affairs, including its escrow operations, if any, and escrow trust accounts, if any, so that the Commissioner may adequately ensure that the title insurance producer is in compliance with this chapter. The Commissioner may prescribe the specific record entries and documents to be kept and the length of time for which the records shall be maintained, for a period of not to exceed 3 years, unless otherwise required by the RESPA.

(Sept. 24, 2010, D.C. Law 18–223, § 2125, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2125 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5041.01.

§ 31–5041.05. Policyholder treatment.

(a) Unless otherwise agreed upon in writing, if a title insurance commitment is issued preparatory to issuing an owners title insurance policy covering the sale of owner-occupied residential property of 4 or fewer units, the title insurance producer or insurer shall furnish

the title insurance commitment no later than the time of closing. The commitment shall be accompanied by the following statement on the 1st page in bold type:

"Please read the exceptions and the terms shown or referred to herein carefully. The exceptions are meant to provide you with notice of matters which are not covered under the terms of the title insurance policy and should be carefully considered.

It is important to note that this form is not a written representation as to the condition of title and may not list all liens, defects, and encumbrances affecting title to the land."

(b)(1) A title insurance producer or insurer which has been requested to issue a lender's title insurance policy in conjunction with a mortgage loan made simultaneously with the purchase of all or part of residential, owner-occupied property securing the loan, where no owner's title insurance policy has been requested, shall give written notice, on a form prescribed or approved by the Commissioner, to the purchaser-mortgagor at the time the commitment is prepared. The notice shall explain:

(A) A lender's title insurance policy is to be issued protecting the mortgage-lender;

(B) The policy does not provide title insurance protection to the purchaser-mortgagor as the owner of the property being purchased;

(C) What a title policy insures against and what possible exposures exist for the purchaser-mortgagor that could be insured against through the purchase of an owner's policy; and

(D) The purchaser-mortgagor may obtain an owner's title insurance policy protecting the property owner at a specified cost or approximate cost, if the proposed coverages or amount of insurance is not then known.

(2) A copy of the notice, signed by the purchaser-mortgagor, shall be retained in the relevant underwriting file at least 3 years after the effective date of the policy.

(Sept. 24, 2010, D.C. Law 18–223, § 2126, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2126 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5041.01.

§ 31–5041.06. Conditions for providing escrow, settlement, closing, and indemnity deposit services.

(a) All funds deposited with the title insurance producer or insurer in connection with an escrow, settlement, closing, or indemnity deposit shall be submitted for collection to or deposited in a fiduciary trust account in accordance with Chapter 24 of Title 42 unless otherwise agreed upon in writing, and in accordance with the following requirements:

(1) The funds shall be the property of the person entitled to them under the provisions of the escrow, settlement, indemnity deposit, or closing agreement and shall be segregated for each depository by escrow, settlement, indemnity deposit, or closing in the records of the title insurance producer in a manner that permits the funds to be identified on an individual basis; and

(2) The funds shall be applied only in accordance with the terms of the individual instructions, settlement statement, or agreements under which the funds were accepted.

(b) Funds held in an indemnity deposit account shall be disbursed only pursuant to a written agreement specifying:

(1) What actions the indemnitor shall take to satisfy his or her obligation under the agreement;

(2) The duties of the title insurance producer with respect to disposition of the funds held, including a requirement to maintain evidence of the disposition of the title exception before any balance may be paid over to the depositing party or his or her designee; and

(3) Any other provisions that the Commissioner may require.

(c) Any interest received on funds deposited in connection with any escrow, settlement, indemnity deposit, or closing shall be paid, net of administrative costs, to the depositing party, unless the depositor's written instructions for the funds, a court order, or a governing law provides otherwise.

(d) Disbursements may be made out of an escrow, settlement, or closing account only if deposits in amounts at least equal to the disbursement have first been made directly relating to the transaction disbursed against and if the deposits are in one of the following forms:

(1) Cash;

(2) Wire transfers such that the funds are unconditionally received by the title insurance producer, title insurer, or depository of either;

(3) Checks, drafts, negotiable orders of withdrawal; money orders, and any other item that has been finally paid before any disbursements; provided, that a title insurance producer may accept a check in an amount not to exceed $3,000 that has not been finally paid before any disbursements;

(4) A depository check, including a certified check, governed by the provisions of the Expedited Funds Availability Act, approved August 10, 1987 (101 Stat. 635; 12 U.S.C. § 4001 *et seq.*); or

(5) Credit transfers through the Automated Clearing House which have been deemed available by the depository institution receiving the credit transfers and conform to the operating rules set forth by the National Automated Clearing House Association.

(e) This chapter shall not prohibit the recording of documents prior to the time funds are available for disbursement with respect to a transaction that does not relate to residential property; provided, that all parties consent to the transaction in writing.

(f) A title insurance producer who maintains or operates fiduciary trust accounts in connection with providing escrow, closing settlement services shall have an annual audit made of its escrow, settlement, closing, and indemnity deposit accounts, conducted by an accountant on a calendar year basis at its expense within 90 days after the close of the previous calendar year. Alternatively, any title insurer, at its expense, may conduct, or cause to be conducted, an annual audit of the escrow, settlement, closing, and security deposit accounts of the title insurance producer, subject to the rules by the Commissioner as hereinafter set forth. By April 30th of each year, the title insurance producer shall provide a copy of the audit report to each title insurer which it represents or for which it was an appointed producer with the Company. The Commissioner may promulgate rules setting forth the minimum threshold level at which an audit would be required, the standards of audit, and the forms of audit report required. Title insurance producers who are attorneys licensed in any state or the District of Columbia, who are not exclusively in the business of title insurance, and who issue title insurance policies as part of their legal representation of clients shall be exempt from the requirements of this subsection; provided, that the title insurer may, at its expense, conduct, or cause to be conducted, an annual review or audit of the escrow, settlement, closing, and indemnity deposit accounts of the attorney. The Commissioner may also require the title insurance producer or escrow agent to provide a copy of its audit report to the Commissioner.

(g) If the title insurance producer is appointed by 2 or more title insurers and maintains fiduciary trust accounts in connection with providing escrow, closing settlement services, the title insurance producer shall allow each title insurer reasonable access to the accounts and any or all of the supporting account information to ascertain the safety and security of the funds held by the title insurance producer.

(h) The Commissioner may prescribe standard disclosures that must be included in all agreements for escrow, settlement, closing, or indemnity deposits.

(Sept. 24, 2010, D.C. Law 18–223, § 2127, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2127 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5041.01.

§ 31–5041.07. Prohibition of rebate and fee splitting.

(a) In a residential property transaction, a title insurer, or any employee or representative of a title insurer, shall not pay, allow, or give, or offer to pay, allow, or give, directly or indirectly, as an inducement to insurance, or after insurance has been effected, any rebate, discount, abatement, credit, or reduction of the premium named in a policy of insurance, or any valuable consideration or inducement, whether or not specified or provided for in the policy, except to the extent provided for in an applicable filing with the Commissioner as provided by law.

(b) In a residential property transaction, an insured named in a policy, or any employee of the insured, shall not knowingly receive or accept, directly or indirectly, any rebate, discount, abatement, credit, or reduction of premium, or any special favor, advantage, valuable consideration, or inducement, as specified in subsection (a) of this section.

(c) This section shall not prohibit:

(1) The payment of commissions or other compensation to domestic or foreign licensed title insurance producers or title insurer employees; or

(2) Any insurer from allowing or returning to its participating policyholders, members, or subscribers dividends, savings, or unabsorbed premium deposits.

(Sept. 24, 2010, D.C. Law 18–223, § 2128, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2122 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5041.01.

§ 31–5041.08. Underwriting contract required with title insurer.

A person acting in the capacity of a title insurance producer shall not place business with a title insurer unless there is in force a written contract between the parties which sets forth the responsibilities of each party, and, if both parties share responsibility for a particular function, specifies the division of the responsibilities.

(Sept. 24, 2010, D.C. Law 18–223, § 2129, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2129 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5041.01.

§ 31–5041.09. Penalties and liabilities.

(a) If the Commissioner determines that the title insurance producer or any other person has violated this chapter, or any rule or order promulgated under this chapter, after notice and opportunity to be heard, the Commissioner may order:

(1) A penalty not exceeding $2,500 for the 1st violation;

(2) A penalty not exceeding $5,000 for each successive violation; and

(3) Revocation or suspension of the title insurance producer's or title insurer's license.

(b) If an order of rehabilitation or liquidation of the insurer has been entered pursuant to Chapter 13 of this title, and the receiver appointed under that order determines that the title insurance producer or any other person has not complied with this chapter, or any related rule or order, and the insurer suffered any resulting loss or damage, the receiver may maintain an action for recovery of damages or other appropriate sanctions for the benefit of the insurer and its policyholders and creditors.

(c) This section shall not affect the right of the Commissioner to impose any other penalties provided for in acts relating to insurance which are codified in this title.

(Sept. 24, 2010, D.C. Law 18–223, § 2130, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2130 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5041.01.

§ 31–5041.10. Violations of the Real Estate Settlement Procedures Act.

The Commissioner or Attorney General for the District of Columbia may bring an action to enjoin or seek remedies for violations of RESPA.

(Sept. 24, 2010, D.C. Law 18–223, § 2131, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2131 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5041.01.

§ 31–5041.11. Rules.

The Commissioner, through the Mayor, pursuant to subchapter I of Chapter 5 of Title 2, may issue rules to implement the provisions of this chapter.

(Sept. 24, 2010, D.C. Law 18–223, § 2132, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2132 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5041.01.

§ 31–5041.12. Applicability; construction.

(a) This chapter shall:

(1) Apply to all persons engaged in the business of title insurance in the District;

(2) Supplement the provisions of Chapter 11A of this title.

(b) This chapter shall not:

(1) Except as otherwise provided, limit the application of any insurance law codified in this title; or

(2) Limit or restrict the rights of policyholders, claimants, and creditors.

(c) If there is a conflict between a provision of this chapter and any other act relating to insurance which is codified in this title, including Chapter 11A of this title, this chapter shall apply.

(d) This chapter shall apply as of January 1, 2011, and to all transactions entered into after January 1, 2011.

(Sept. 24, 2010, D.C. Law 18–223, § 2133, 57 DCR 6242.)

Historical and Statutory Notes

Emergency Act Amendments

For temporary (90 day) addition, see § 2133 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18–463, July 2, 2010, 57 DCR 6542).

Legislative History of Laws

For Law 18–223, see notes following § 31–5041.01.

SUBTITLE VIII–A
CERTIFIED CAPITAL INVESTMENT BY INSURANCE COMPANIES.

Chapter 52A
Certified Capital Companies.

Section	
31–5231.	Definitions.
31–5235.	Requirements for continuance of certification.
31–5236.	One hundred percent investment requirement.
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31–5238.03.	Waivers and disqualifications.

§ 31–5231. Definitions.

For the purpose of this chapter, the term:

(1) "Affiliate" means:

(A) Any person, directly or indirectly, beneficially owning (whether through rights, options, convertible interests, or otherwise), controlling, or holding power to vote 15% or more of the outstanding voting securities or other voting ownership interests of the Certified Capital Company or Certified Investor;

(B) Any person with 15% or more of its outstanding voting securities or other voting ownership interests directly or indirectly beneficially owned (whether through rights, options, convertible interests, or otherwise), controlled, or held with power to vote by the Certified Capital Company or Certified Investor;

(C) Any person directly or indirectly controlling, controlled by, or under common control with the Certified Capital Company or Certified Investor;

(D) A partnership or limited liability company in which the Certified Capital Company or Certified Investor is a general partner, manager, or managing member; or

(E) Any person who is an officer, director, employee, or agent of the Certified Capital Company or Certified Investor or an immediate family member of the officer, director, employee, or agent.

(2) "Allocation Date" means the date on which the Certified Investors of a Certified Capital Company are allocated Premium Tax Credits by the Commissioner under § 31–5234.

(3) "Certified Capital" means an investment of cash by a Certified Investor in a Certified Capital Company that fully funds the purchase price of an equity interest in the Certified Capital Company, a Qualified Debt Instrument, or a combination of the two.

(4) "Certified Capital Company" means a partnership, corporation, trust, or limited liability company, whether organized on a profit or not for profit basis, that has as its primary business activity the investment of cash in Qualified Businesses and that is certified by the Commissioner as meeting the criteria of this chapter.

(5) "Certified Investor" means any insurance company, approved by the Commissioner, that invests Certified Capital pursuant to an allocation of Premium Tax Credits under § 31–5234.

(6) "Commissioner" means the Commissioner of Insurance and Securities Regulation.

(7) "District" means the District of Columbia.

(8) "District Premium Tax Liability" means any liability incurred by an insurance company under § 31–205 or, in the case of a repeal or reduction by the District of the tax imposed by § 31–205, any other tax liability incurred by an insurance company under District law.

(8A) "Economic Impact Study" means an assessment of the performance of the Certified Capital Company program that includes:

(A) Job growth and retention in Qualified Businesses after the receipt of Qualified Investments, with reference to the following measures:

(i) Overall number of jobs created and retained;

(ii) Number of jobs created and retained in Tier One Qualified Businesses, Tier Two Qualified Businesses, and Tier Three Qualified Businesses; and

(iii) A description of whether the jobs are full-time salaried, full-time hourly, part-time, or contract;

(B) Estimates of the taxation revenue generated as the result of Qualified Investments, with specific reference to income tax, sales tax, and corporate tax; and

(C) Comparison of each of the measures set forth in subparagraphs (A) and (B) of this paragraph among all Certified Capital Companies.

(8B) "Follow-on Investment" means any Qualified Investment that a Certified Capital Company makes in a Qualified Business that is subsequent to its Initial Investment in that Qualified Business.

(8C) "Initial Investment" means the 1st Qualified Investment that a Certified Capital Company makes in a Qualified Business after May 27, 2010.

(9) "Person" means any natural person or entity, including a corporation, general or limited partnership, trust, or limited liability company.

(10) "Premium Tax Credit" means a tax credit which may be applied against a Certified Investor's District Premium Tax Liability under § 31–5233.

(11) "Premium Tax Credit Allocation Request" means an application for allocation of Premium Tax Credits prepared and executed by a Certified Investor on a form provided by the Commissioner and filed by a Certified Capital Company with the Commissioner.

(11A) "Principal Business Operations" means the location where a business conducts its primary business activities, its managers and the majority of its employees work, and its material books and records are maintained.

(12)(A) "Qualified Business" means a business, except as provided in subparagraph (B) of this paragraph, that meets the following qualifications as of the time of a Certified Capital Company's Initial Investment in the business:

(i)(I) It is headquartered in the District, its Principal Business Operations are located in the District, and the Qualified Investment it receives is used solely to support its business operations in the District, except for advertising, promotions, and sales purposes; or

(II) It is headquartered and has its Principal Business Operations located outside the District, certifies in an affidavit that the business will relocate its headquarters and its Principal Business Operations to the District within 90 days after its receipt of the Initial Investment by the Certified Capital Company, and the Qualified Investment it receives is used solely to support its business operations in the District, except for advertising, promotions, and sales purposes;

(ii) At least 25% of its employees are residents of the District;

(iii) At least 75% of its employees are employed in the District;

(iv) It is a small business concern as defined in 13 C.F.R. § 121.201;

(v) It certifies in an affidavit that the business is unable to obtain conventional financing, which means that the business has failed in an attempt to obtain funding for a loan from a bank or other commercial lender or that the business cannot reasonably be expected to qualify for financing under the standards of commercial lending;

(vi) The business was not organized by a Certified Capital Company or an affiliate of a Certified Capital Company; provided, that this sub-subparagraph shall not prohibit a Certified Capital Company from providing financial, technical, or similar advice to a business before making an investment in such business;

(vii) The business does not have an ownership interest, investment interest, compensation agreement, or similar financial relationship with a Certified Capital Company or any affiliate of a Certified Capital Company before the date on which a Certified Capital Company makes an Initial Investment in the business; provided, that this sub-subparagraph shall not prohibit a Certified Capital Company from providing financial, technical or similar advice to a business before making an investment in such business.

(B) A business shall not be a Qualified Business if it is:

(i) A regional or national franchise;

(ii) Primarily engaged in real estate development or leasing projects;

(iii) Primarily engaged in insurance; or

(iv) Engaged in the provision of professional services by accountants, lawyers, or physicians.

(13) "Qualified Debt Instrument" means a debt instrument issued to a Certified Investor by a Certified Capital Company, at par value or a premium, with an original maturity date of at least 5 years from date of issuance and a repayment schedule which is no faster than a level principal amortization over 5 years, which does not permit the Certified Investor to receive prepayment of interest, and which contains no interest, distribution, or payment features which are related to the profitability of the issuing Certified Capital Company or the performance of its investment portfolio.

(14) "Qualified Distribution" means any distribution or payment of a Certified Capital Company in connection with the following:

(A) Reasonable costs and expenses of forming and syndicating the Certified Capital Company, which may include the costs of financing and insuring the obligations of the Certified Capital Company; provided, that no more than one Certified Investor, or the Affiliates thereof, in the Certified Capital Company may receive a Qualified Distribution related to providing a guaranty, indemnity, bond, insurance policy, or other payment undertaking in favor of all of the Certified Investors;

(B) Reasonable costs and expenses of managing and operating the Certified Capital Company, including reasonable and necessary fees paid for professional services (such as legal and accounting services) related to the formation and operation of the Certified Capital Company and an annual management fee in an amount that does not exceed 2 1/2 of the Certified Capital of the Certified Capital Company; and

(C) Any projected increase in federal or state taxes of the direct or indirect equity holders of a Certified Capital Company resulting from the earnings or other tax liability of the Certified Capital Company to the extent that the increase is related to the direct or indirect ownership of a Certified Capital Company.

(15) "Qualified Investment" means the investment of cash by a Certified Capital Company in a Qualified Business for the purchase of any debt, debt participation, equity, or hybrid security, of any nature and description, including a debt instrument or security which has the characteristics of debt but which provides for conversion into equity or equity participation instruments, such as options or warrants; provided, that:

(A) Any such debt instrument shall have a maturity of at least 24 months from the date the debt is incurred; and

(B) A Certified Capital Company, after an investment and assuming the conversion and exercise of any equity participation or hybrid security, shall not own more than 49% of the voting equity of the Qualified Business.

(16) "Tier One Qualified Business" means any Qualified Business:

(A) That did not receive a Qualified Investment prior to May 27, 2010;

(B) That is engaged in one of the following lines of business as its primary line of business:

(i) Healthcare services;

(ii) Information technology;

(iii) Environmental services/technology;

(iv) Internet information providers;

(v) Communication services;

(vi) Biotechnology/research services;

(vii) Multimedia/graphics software;

(viii) Business management services;

(ix) Financial services; or

(x) Restaurant services; and

(C) Whose Principal Business Operations are located within:

(i) A Neighborhood Investment Program target area designated pursuant to § 6–1073; or

(ii) The District of Columbia Enterprise Zone as defined by section 1400 of the Internal Revenue Code of 1986, approved August 5, 1997 (111 Stat. 863; 26 U.S.C. § 1400).

(17) "Tier Two Qualified Business" means any Qualified Business that did not receive a Qualified Investment prior to May 27, 2010, that is not a Tier One Qualified Business, and that is engaged in one of the lines of business set forth in paragraph (16)(B)(i) through (x) of this section as its primary line of business.

(18) "Tier Three Qualified Business" means any Qualified Business that did not receive a Qualified Investment prior to May 27, 2010, and that is not a Tier One Qualified Business or a Tier Two Qualified Business.

(Mar. 10, 2004, D.C. Law 15–87, § 2, 50 DCR 10982; Apr. 13, 2005, D.C. Law 15–354, § 49(a), 52 DCR 2638; May 27, 2010, D.C. Law 18–181, § 2(a), 57 DCR 3388.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 18–181 added pars. (8A), (8B), (8C), (11A), and (16) to (18); and rewrote pars. (12) and (15), which had read as follows:

"(12)(A) 'Qualified Business' means a business, except as provided in subparagraphs (B) and (C) of this paragraph, that meets the following qualifications as of the time of a Certified Capital Company's initial investment in the business:

"(i) It is headquartered in the District, its principal business operations are located in the District, and the Qualified Investment it receives is used solely to support its business operations in the District, except for advertising, promotions and sales purposes;

"(ii) At least 25% of its employees are residents of the District;

"(iii) At least 75% of its employees are employed in the District;

"(iv) It is a small business concern as defined in 13 CFR § 121.201; and

"(v) It certifies in an affidavit that the business is unable to obtain conventional financing, which means that the business has failed in an attempt to obtain funding for a loan from a bank or other commercial lender or that the business cannot reasonably be expected to qualify for financing under the standards of commercial lending.

"(B) A business engaged in professional services provided by accountants, lawyers, or physicians shall not constitute a Qualified Business.

"(C) A business that does not meet all of the qualifications set forth in subparagraph (A) of this paragraph may be deemed a Qualified Business for purposes of allowing an investment in the business by a Certified Capital Company if the Commissioner determines that the proposed investment will further economic development in the District and certifies the business as a Qualified Business for purposes of the investments.

"(15) 'Qualified Investment' means the investment of cash by a Certified Capital Company in a Qualified Business for the purchase of any debt, debt participation, equity, or hybrid security, of any nature and description, including a debt instrument or security which has the characteristics of debt but which provides for conversion into equity or equity participation instruments, such as options or warrants."

Legislative History of Laws

Law 18–181, the "Certified Capital Companies Amendment Act of 2010", was introduced in Council and assigned Bill No. 18–402, which was referred to the Committee on Public Services and Consumer Affairs. The bill was adopted on first and second readings on March 2, 2010, and March 16, 2010, respectively. Signed by the Mayor on April 7, 2010, it was assigned Act No. 18–378 and transmitted to both Houses of Congress for its review. D.C. Law 18–181 became effective on May 27, 2010.

Miscellaneous Notes

Section 3 of D.C. Law 18–181 provides:

"Sec. 3. Applicability.

"This act shall not apply to any Qualified Investment or distribution made by any Certified Capital Company prior to the effective date of this act."

§ 31–5235. Requirements for continuance of certification.

(a) To continue to be certified, a Certified Capital Company shall make Qualified Investments according to the following schedule:

(1) Within the period ending 30 months after its Allocation Date, a Certified Capital Company shall have made Qualified Investments cumulatively equal to 20% of its Certified Capital;

(2) Within the period ending 4 years after its Allocation Date, a Certified Capital Company shall have made Qualified Investments cumulatively equal to 40% of its Certified Capital;

(3) Within the period ending 5 years after its Allocation Date, a Certified Capital Company shall have made Qualified Investments cumulatively equal to 50% of its Certified Capital; and

(4) Within the period ending 10 years after its Allocation Date, a Certified Capital Company shall have made Qualified Investments cumulatively equal to 100% of its Certified Capital.

(b)(1) The aggregate cumulative amount of all Qualified Investments made by the Certified Capital Company following its Allocation Date shall be considered in the calculation of the percentage requirements under this chapter. Any proceeds received from a Qualified Investment may be invested in another Qualified Investment and shall count toward any requirement in this chapter with respect to investments of Certified Capital.

(2) For the purposes of satisfying the percentage requirements of subsection (a) of this section only, for each Qualified Investment made after May 27, 2010, a Certified Capital Company that invests in a:

(A) Tier One Qualified Business shall be deemed to have invested $1.25 for every dollar invested;

(B) Tier Two Qualified Business shall be deemed to have invested $1.00 for every dollar invested;

(C) Tier Three Qualified Business shall be deemed to have invested $0.75 for every dollar invested;

(D) Qualified Business that receives an Initial Investment pursuant to a waiver granted in accordance with § 31–5238.03 and that fails to satisfy the eligibility criteria to receive an Initial Investment within 6 months of the date of issuance of the waiver shall be deemed to have invested $0 for every dollar invested;

(E) Qualified Business that received a Qualified Investment prior to May 27, 2010, and receives a subsequent Qualified Investment after May 27, 2010, shall be deemed to have invested $1.00 for every dollar invested; and

(F) Qualified Business that receives an Initial Investment or a Follow-on Investment and that fails to maintain satisfaction of the eligibility criteria to receive an Initial or a Follow-on Investment, as applicable, for 6 consecutive months after the date of the Initial or Follow–On Investment shall be deemed to have invested $0 for every dollar invested.

(c) Notwithstanding any other provision in this chapter, any Qualified Business that has received an Initial Investment may receive a Follow-on Investment if it:

(1) Continues to meet the definition of a Qualified Business other than the requirements set forth in § 31–5231(12)(A)(iv) and (v); and

(2) Certifies in an affidavit that it intends to maintain its headquarters and Principal Business Operations in the District.

(d) No Qualified Investment shall exceed 15% of the total Certified Capital of the Certified Capital Company at the time of investment.

(e) A Certified Capital Company, at least 20 business days prior to making an Initial Investment or Follow-on Investment in a business, shall:

(1) Certify in an affidavit that the business in which it proposes to invest:

(A) In the case of an Initial Investment, is a Qualified Business; or

(B) In the case of a Follow-on Investment, is eligible for a Follow-on Investment pursuant to subsection (c) of this section; and

(2) Submit, along with the certification required by paragraph (1) of this subsection, an explanation of its determination that the business is eligible for an Initial Investment or Follow-on Investment.

(e–1) If, after receiving the affidavit and certification under subsection (e) of this section, the Commissioner determines that a business is not eligible for an Initial Investment or a Follow-on Investment, the Commissioner shall, within 20 days of receiving the affidavit and certification, notify the Certified Capital Company of the determination and provide an explanation.

(f) All Certified Capital not placed in Qualified Investments by the Certified Capital Company may be held or invested in a manner that the Certified Capital Company, in its

discretion, considers appropriate; provided, that the Certified Capital Company shall not invest more than 5% of its Certified Capital in any security or policy issued by a Certified Investor or an Affiliate of a Certified Investor or any account maintained by a Certified Investor or Affiliate of any Certified Investor, unless the Certified Investor or an Affiliate thereof is providing a guaranty, indemnity, bond, insurance policy, or other payment undertaking in favor of the Certified Investors, which security or policy is:

(1)(A) Rated "AA" or better by Standard & Poor's Ratings Group or the equivalent by another nationally-recognized rating agency; or

(B) Issued by, or guaranteed with respect to payment by, an entity whose unsecured indebtedness is rated at least "AA" or its equivalent by a nationally recognized credit rating organization; and

(2) Not subordinated to other unsecured indebtedness of the issuer or the guarantor, as the case may be.

(g) Each Certified Capital Company shall report to the Commissioner as follows:

(1) Within 5 business days after the receipt of Certified Capital, each Certified Capital Company shall report the following to the Commissioner:

(A) The name of each Certified Investor from which the Certified Capital was received, including the Certified Investor's insurance premium tax identification number;

(B) The amount of each Certified Investor's investment of Certified Capital and Premium Tax Credits; and

(C) The date on which the Certified Capital was received.

(2) On or before January 31st of each year, each Certified Capital Company shall report the following to the Commissioner:

(A) The amount of the Certified Capital Company's Certified Capital at the end of the immediately preceding year;

(B) Whether or not the Certified Capital Company has invested more than 15% of its total Certified Capital in any one business; and

(C)(i) All Qualified Investments that the Certified Capital Company made during the previous calendar year, including the number of employees of each Qualified Business in which it has made investments at the time of such investment and as of December 1st of the preceding calendar year; and

(ii) For any Qualified Business in which the Certified Capital Company no longer has an investment, the Certified Capital Company shall provide employment figures for the Qualified Business at the time of such investment and as of the last day before the investment was terminated.

(3) Each Certified Capital Company shall provide to the Commissioner annual audited financial statements, which shall include the opinion of an independent certified public accountant, within 120 days after the end of the fiscal year. In addition, each Certified Capital Company shall provide an agreed–upon procedures report by their independent certified public accountant that shall address the methods of operation and conduct of the business of the Certified Capital Company to determine if the Certified Capital Company is complying with this chapter and the rules and regulations hereunder and that the Certified Capital has been invested as required within the time limits under subsection (a) of this section.

(4) On or before January 31st of each year, each Certified Capital Company shall pay an annual, nonrefundable certification fee of $10,000 to the Commissioner; provided, that no fee shall be required within 6 months of the initial Allocation Date.

(h) After May 27, 2010, if a Certified Capital Company makes a Qualified Investment in a business that relocates its Principal Business Operations outside the District prior to the termination of the Qualified Investment or within 6 months after the termination of the Qualified Investment, the cumulative Qualified Investments that the Certified Capital Company will be deemed to have made for the purposes of § 31–5236 will be reduced by the amount of the Qualified Investment in the business that relocated its Principal Business Operations outside the District, unless the business demonstrates that it has returned its Principal Business Operations to the District within 3 months of the relocation.

(Mar. 10, 2004, D.C. Law 15–87, § 6, 50 DCR 10982; Apr. 13, 2005, D.C. Law 15–354, § 49(c), 52 DCR 2638; May 27, 2010, D.C. Law 18–181, § 2(b), 57 DCR 3388.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 18–181, in subsec. (a), deleted "; and" from the end of par. (2), substituted "; and" for a period at the end of par. (3), and added par. (4); rewrote subsecs. (b), (c), (e), and (g)(2)(C); and added subsecs. (e–1) and (h). Prior to amendment, subsecs. (b), (c), (e), and (g)(2)(C) read as follows:

"(b) The aggregate cumulative amount of all Qualified Investments made by the Certified Capital Company following its Allocation Date will be considered in the calculation of the percentage requirements under this chapter. For purposes of satisfying the percentage requirements of subsection (a) of this section only, a Certified Capital Company that invests in a Qualified Business that certifies in an affidavit that at least 80% of its employees, at the time of the investment, are residents of the District shall be deemed to have invested $1.50 for every dollar actually so invested. Any proceeds received from a Qualified Investment may be invested in another Qualified Investment and shall count toward any requirement in this chapter with respect to investments of Certified Capital.

"(c) A Qualified Business at the time of first investment in the business by a Certified Capital Company shall remain classified as a Qualified Business. The business may receive additional investments from any Certified Capital Company if it continues to meet the qualifications for a Qualified Business and the additional investments shall be Qualified Investments; provided, that the Commissioner may waive one or more of the requirements for qualification as for a Qualified Business if the business was a Qualified Business at the time of the initial investment."

"(e) At its option, a Certified Capital Company, prior to making an investment in a specific business, may request from the Commissioner a written opinion that the business is a Qualified Business. Upon receiving the request, the Commissioner shall have 15 days to determine whether or not the business is a Qualified Business and notify the Certified Capital Company of its determination and an explanation. If the Commissioner fails to notify the Certified Capital Company with respect to the proposed investment within the 15–day period, the business shall be deemed to be a Qualified Business."

"(C) All Qualified Investments that the Certified Capital Company made during the previous calendar year."

Legislative History of Laws

For Law 18–181, see notes following § 31–5231.

§ 31–5236. One hundred percent investment requirement.

(a) A Certified Capital Company may make Qualified Distributions at any time. To make a distribution, other than a Qualified Distribution, a Certified Capital Company shall have made Qualified Investments in an amount cumulatively equal to 100% of its Certified Capital. A Certified Capital Company may repay principal and interest on its indebtedness without any restriction, including repayments of indebtedness of the Certified Capital Company on which Certified Investors earned Premium Tax Credits.

(a–1) Notwithstanding any other provision in this chapter, if, pursuant to § 31–5235(a)(4), a Certified Capital Company has not made Qualified Investments cumulatively equal to 100% of its Certified Capital within 10 years after its Allocation Date, the Certified Capital Company shall be prohibited from using its Certified Capital to pay its management fees.

(b)(1) When distributions to holders of equity interests of a Certified Capital Company cumulatively exceed the Certified Capital Company's original Certified Capital plus any additional capital contributions to the Certified Capital Company (the "Certified Capital Company Capital"), the Certified Capital Company shall report to the Commissioner at the time of the distribution whether the aggregate total of such distributions, when combined with the annual Premium Tax Credits allocated to the Certified Capital Company's Certified Investors under this chapter to that time, have resulted in an annual internal rate of return exceeding 15% on the Certified Capital Company Capital.

(2) If the Certified Capital Company's annual internal rate of return, determined in accordance with paragraph (1) of this subsection, exceeds 15%, the Certified Capital Company shall at the time of the distribution pay to the Commissioner an amount equal to 15% of the amount above that required to produce the 15% return.

(Mar. 10, 2004, D.C. Law 15–87, § 7, 50 DCR 10982; May 27, 2010, D.C. Law 18–181, § 2(c), 57 DCR 3388.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 18–181 added subsec. (a–1).

Legislative History of Laws

For Law 18–181, see notes following § 31–5231.

§ 31–5237. Decertification.

(a) The Commissioner shall conduct an annual review of each Certified Capital Company to determine if the Certified Capital Company is complying with the requirements of certification, to advise the Certified Capital Company as to the eligibility status of its Qualified Investments, and to ensure that no investment has been made in violation of this chapter. The cost of the annual review shall be paid by each Certified Capital Company under a fee schedule adopted by the Commissioner.

(b) Any material violation of this chapter shall be grounds for decertification of the Certified Capital Company. If the Commissioner determines that a Certified Capital Company is not in compliance with the requirements of this chapter, the Commissioner shall, by written notice, inform the officers of the Certified Capital Company that the Certified Capital Company is subject to decertification in 120 days from the date of mailing of the notice unless the deficiencies are corrected.

(c) If the Certified Capital Company is not in compliance with this chapter at the end of the 120–day notice period , the Commissioner may send a notice of decertification to the Certified Capital Company and to all other appropriate District agencies.

(d) Decertification of a Certified Capital Company may cause the recapture of Premium Tax Credits previously claimed and the forfeiture of future Premium Tax Credits to be claimed by Certified Investors with respect to the Certified Capital Company, as follows:

(1) Decertification of a Certified Capital Company within 3 years of the Allocation Date shall cause the recapture of all Premium Tax Credits previously claimed and the forfeiture of all future Premium Tax Credits to be claimed by Certified Investors unless the Certified Capital Company has met the requirements for continued certification as provided in this subsection.

(2) If a Certified Capital Company has met all requirements for continued certification under § 31–5235(a)(1) and subsequently fails to meet the requirements for continued certification under the provisions of § 31–5235(a)(2), the Premium Tax Credits which have been or could be taken, subject to the other provisions of this chapter, by Certified Investors within 3 years from the Allocation Date shall not be subject to recapture or forfeiture; provided, that all other Premium Tax Credits shall be subject to recapture or forfeiture.

(3) If a Certified Capital Company has met all requirements for continued certification under § 31–5235(a)(1) and (2) and is subsequently decertified, the Premium Tax Credits which have been or could be taken, subject to the other provisions of this chapter, by Certified Investors within 4 years from the Allocation Date shall not be subject to recapture or forfeiture; provided, that all other Premium Tax Credits shall be subject to recapture or forfeiture.

(4) If a Certified Capital Company has met all requirements for continued certification under § 31–5235(a)(1), (2), and (3) and is subsequently decertified, those Premium Tax Credits which have been or could be claimed, subject to the other provisions of this chapter, by Certified Investors within 5 years from the Allocation Date shall not be subject to recapture or forfeiture. The Premium Tax Credits to be claimed subsequent to the 5th anniversary of the Allocation Date shall be subject to forfeiture only if the Certified Capital Company is decertified within 5 years from the Allocation Date.

(5) If a Certified Capital Company has invested an amount cumulatively equal to 100% of its Certified Capital in Qualified Investments, notwithstanding any other provision of this chapter, all Premium Tax Credits shall not be subject to recapture or forfeiture.

(e) If a Certified Capital Company has invested an amount cumulatively equal to 100% of its Certified Capital in Qualified Investments, notwithstanding any other provision of this chapter, the Certified Capital Company shall not be subject to regulation by the Commissioner.

(f) The Commissioner shall send written notice to each Certified Investor whose Premium Tax Credits have been subject to recapture or forfeiture at the address last shown on the last premium tax filing.

(g) Repealed.

(Mar. 10, 2004, D.C. Law 15–87, § 8, 50 DCR 10982; May 27, 2010, D.C. Law 18–181, § 2(d), 57 DCR 3388.)

Historical and Statutory Notes

Effect of Amendments

D.C. Law 18–181, in subsecs. (a) and (b), substituted "this chapter" for "§ 31–5235"; and repealed subsec. (g), which had read as follows:

"(g) The Commissioner may waive, pursuant to rules established pursuant to § 31–5239, any recapture or forfeiture of credits if, after considering all facts and circumstances, he or she determines that the waiver will have the effect of furthering the District's economic development."

Legislative History of Laws

For Law 18–181, see notes following § 31–5231.

§ 31–5238.02. Compliance and economic impact.

(a) Information, records, or other data received, prepared, used, or retained by the Commissioner pursuant to this subsection shall not be subject to the disclosure requirements of subchapter II of Chapter 5 of Title 2 to the extent that:

(1) The information, records, or other data describe the commercial and financial operations or intellectual property of a business entity or individual;

(2) The information or records have not been publicly disseminated at any time; and

(3) Disclosure of the information or records may put the business entity or individual at a competitive disadvantage.

(b)(1) A Certified Capital Company shall receive and consider applications from every business interested in obtaining funds from the Certified Capital Company. The Certified Capital Company shall maintain a registry of all contacts made with every person or business that contacts the Certified Capital Company for the purpose of obtaining funding. The registry shall be made available to the Commissioner for inspection.

(2) A Certified Capital Company shall provide, at the Commissioner's request, the Commissioner with a detailed written explanation explaining its decision to fund or to decline to fund a prospective business. A Certified Capital Company providing a written explanation pursuant to this paragraph shall include a copy of the prospect's business plan, financial statements, or other documents submitted by the person or business seeking funding. A Certified Capital Company shall also submit to the Commissioner all internal business analysis documents, if any, prepared by the Certified Capital Company that were considered during its decision-making process.

(3) A Certified Capital Company that declines to provide funding to any business shall promptly communicate its decision in writing to the business seeking the funding. The letter shall include a detailed statement describing the reason the Certified Capital Company declined to fund the business. A copy of the letter shall be sent to the Commissioner.

(c)(1) Each Qualified Business shall once a year provide the Certified Capital Companies from which it has received a Qualified Investment with a report stating the number and type of jobs created and retained in total and in the District, salaries paid to each employee, taxes paid to the District, money spent with local businesses or persons, including landlords, major suppliers and vendors, accountants, auditors, attorneys, and others, and whether such businesses or persons are located in the District or elsewhere.

(2) Each Qualified Businesses shall provide the Certified Capital Company with documents, such as leases, invoices, payroll reports, employment records, tax returns and contracts, in support of the reports required by paragraph (1) of this subsection. The Certified Capital Company shall maintain the reports and supporting documents for a period of not less than 5 years from the date of receipt and shall make this information available to the Commissioner during the annual review.

(d) Notwithstanding any other provision in this chapter, the Commissioner shall promptly make available to the Council and its committees, upon their request, any information made available to or otherwise in the possession of the Commissioner pursuant to this chapter.

(e) The Commissioner shall conduct an Economic Impact Study once a year, beginning with the year ending December 31, 2009, and ending with the year ending December 31, 2014,

to determine the economic impact of the Certified Capital Company program on the District's economy. The Certified Capital Companies shall require its Qualified Businesses to provide all information necessary, as determined by the Commissioner or his or her designee, to complete the study. A detailed written report shall be prepared at the conclusion of the study. The Commissioner may retain consultants, economists, and other experts to conduct the Economic Impact Study. The costs of these experts shall be borne by the Certified Capital Companies in proportion to the amount of Certified Capital invested in each Certified Capital Company.

(f) The Commissioner may subject a Certified Capital Company to an administrative penalty not to exceed $25,000 for any violation of this section, subject to the hearing requirements set forth in § 2–509. Prior to imposing a penalty under this section, the Commissioner shall provide the Certified Capital Company with written notice of the violation and at least 30 days to cure the violation.

(Mar. 10, 2004, D.C. Law 15–87, § 9a, as added by May 27, 2010, D.C. Law 18–181, § 2(e), 57 DCR 3388.)

Historical and Statutory Notes

Legislative History of Laws

For Law 18–181, see notes following § 31–5231.

§ 31–5238.03. Waivers and disqualifications.

The Commissioner may grant a business a 6–month waiver from any of the eligibility criteria to receive an Initial Investment if the Commissioner finds that the business will meet the eligibility criteria to receive an Initial Investment within 6 months of the date of issuance of the waiver. The waiver shall expire 6 months after it is issued and a business shall not receive an additional waiver pursuant to this section. Upon satisfaction of all eligibility criteria within the 6–month period, the business shall promptly provide the Commissioner with an affidavit stating that the business has satisfied the eligibility criteria to receive an Initial Investment and shall provide any supporting documents requested by the Commissioner.

(Mar. 10, 2004, D.C. Law 15–87, § 9b, as added May 27, 2010, D.C. Law 18–181, § 2(e), 57 DCR 3388.)

Historical and Statutory Notes

Legislative History of Laws

For Law 18–181, see notes following § 31–5231.

SUBTITLE X
SECURITIES.

Chapter 56
Securities

Subchapter I. Definitions and Rules of Construction.

Section
31–5601.01. Definitions.

SUBCHAPTER I. DEFINITIONS AND RULES OF CONSTRUCTION.

§ 31–5601.01. Definitions.

For the purposes of this chapter, the term:

(1) "Accredited investor" shall have the same meaning as in section 2(a)(15) of the Securities Act of 1933, approved May 27, 1933 (48 Stat. 74; 15 U.S.C. § 77b(a)(15)), or any

other person that the Securities and Exchange Commission may so designate by rule, regulation, or order.

(1A) "Advertisement" means a publicly disseminated, written, or printed communication, including by radio, television, Internet, or other public media, used in connection with a sale or purchase, or an offer to sell or purchase, a security.

(2) "Affiliate" of, or a person "affiliated" with, a specified person, means a person that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with, the person specified.

(3)(A) "Agent" means an individual, other than a broker-dealer, who represents a broker-dealer or issuer in effecting, or attempting to effect, purchases or sales of securities. The term "agent" shall not include:

(i) An individual who represents a broker in effecting transactions in the District of Columbia ("District") limited to transactions described in section 15(h)(2) of the Securities Exchange Act of 1934;

(ii) An individual who represents an issuer in effecting transactions in a security exempted by § 31–5604.01(1), (2), (3), (4), (5), (6), (7), (8), (9), or (10);

(iii) An individual who represents an issuer in effecting transactions exempted by § 31–5604.02;

(iv) An individual who represents an issuer in effecting a transaction in a covered security as described in section 18(b)(3) and (b)(4)(D) of the Securities Act of 1933;

(v) An individual who represents an issuer in effecting transactions with existing employees, partners, or directors of the issuer if no commission or other remuneration is paid or given, directly or indirectly, for soliciting a person in the District; or

(vi) A person not within the intent of this paragraph as the Commissioner may, by rule or order, determine.

(B) A partner, including a general partner, officer, or director of a broker-dealer or issuer, or a person occupying a similar status or performing similar functions, is an agent only if (i) the person otherwise comes within this definition, and (ii) any compensation that he or she receives is directly or indirectly related to purchases or sales of securities.

(4) "Broker-dealer" means a person engaged in the business of effecting offers, purchases, or sales in securities for the account of others or for his or her own account. The term "broker-dealer" shall not include:

(A) An agent;

(B) An issuer, except when effecting purchases, offers, or sales other than with respect to the offer or sale of the issuer's own securities;

(C) A depository institution to the extent that the depository institution is a bank under section 3(a)(4)(B) and (C) of the Securities Exchange Act of 1934, approved June 6, 1934 (48 Stat. 881; 15 U.S.C. § 78c(a)(4)(B) and (C)); or

(D) A person who has no place of business in the District if:

(i) The person effects, whether acting for itself or as trustee, transactions in the District exclusively with or through the issuers of the securities involved in the transactions; a depository institution; another broker-dealer; an insurance company; an investment company as defined in the Investment Company Act of 1940; a pension or profit-sharing trust; or other financial institution or institutional investor; or

(ii) The person is licensed under the securities law of a state in which the person maintains a place of business and the person offers and sells in the District to a person who is an existing customer of the person.

(4A) "Canadian broker-dealer" means a broker-dealer that has its principal office in a province or territory of Canada.

(5) "Commissioner" means the Commissioner of the Department of Insurance, Securities, and Banking.

(6) "Commodity Exchange Act" means the Commodity Exchange Act, approved September 21, 1922 (42 Stat. 998; 7 U.S.C. § 1 et seq.).

(7) "Control", including the terms "controlling", "controlled by", and "under common control with", means the possession, directly or indirectly, of the power to direct or cause the direction of the management or policies of a person, whether through the ownership of voting securities, by contract, or otherwise.

(8) "Department" means the Department of Insurance, Securities, and Banking.

(9)(A) "Depository institution" means:

(i) A person that is organized, chartered, or holds an authorization certificate under the laws of a state or of the United States to receive deposits, including a savings, share, certificate, or deposit account, and that is supervised and examined for the protection of depositors by an official or agency of a state or the United States; and

(ii) A trust company or other institution that is authorized by federal or state law to exercise fiduciary powers of the type that a national bank is permitted to exercise under the authority of the Comptroller of the Currency and is supervised and examined by an official or agency of a state or the United States.

(B) The term "depository institution" shall not include an insurance company or other organization primarily engaged in the insurance business or a Morris Plan bank, industrial loan company, or a similar bank or company unless its deposits are insured by a federal agency.

(10) "Federal covered adviser" means a person who is registered, or required to be registered, under section 203 of the Investment Advisers Act of 1940. The term "federal covered adviser" shall not include a person who is not an investment adviser as defined under paragraph 17(B)(ii) through (xiii) of this section.

(11) "Federal covered security" means a security which is a covered security under section 18(b) of the Securities Act of 1933 or the rules and regulations promulgated thereunder.

(12) "Filed" means the actual delivery of a document or application to the Commissioner or designee of the Commissioner or to the principal office of the Commissioner.

(13) "Financial or institutional investor" means any of the following, whether acting for itself or others in a fiduciary capacity:

(A) A depository institution;

(B) An insurance company;

(C) A separate account of an insurance company;

(D) An investment company registered under the Investment Company Act of 1940;

(E) A business development company as defined in the Investment Company Act of 1940;

(F) An employee pension, profit-sharing, or benefit plan if:

(i) The plan has total assets in excess of $5 million; or

(ii) Its investment decisions are made by a named fiduciary, as defined in the Employee Retirement Income Security Act of 1974, that is either a broker-dealer registered under the Securities Exchange Act of 1934, an investment adviser registered or exempt from registration under the Investment Advisers Act of 1940, a depository institution, or an insurance company;

(G) A "qualified institutional buyer" as defined in SEC Rule 144A, 17 C.F.R. § 230.144A;

(H) A broker-dealer;

(I) An accredited investor as defined in SEC Rule 501(a), 17 C.F.R. § 230.501(a);

(J) A limited liability company with net assets of at least $500,000.

(K) Repealed.

(14) "Fraud", "deceit", and "defraud" are not limited to common law fraud or deceit.

(15) "Guaranteed" means guaranteed as to payment of all, or substantially all, of principal and interest or dividends.

(16) "Insured" means insured as to payment of all, or substantially all, of principal and interest or dividends.

(17)(A) "Investment adviser" means a person who, for compensation (i) engages in the business of advising others as to the value of securities or as to the advisability of investing in, purchasing, or selling securities, or (ii) as a part of a regular business, issues or promulgates analyses or reports concerning securities. The term "investment adviser" shall include financial planners or other persons who, as an integral component of other financially related services, provide investment advisory services to others for compensation, or as a part of a business, hold themselves out as providing investment advisory services to others for compensation.

(B) The term "investment adviser" shall not include:

(i) A federal covered adviser;

(ii) An investment adviser representative;

(iii) A depository institution or a person employed by, or directly associated with, a depository institution;

(iv) A lawyer, accountant, engineer, insurance agent or broker, or teacher whose performance of investment advisory services is solely incidental to the practice of the person's profession;

(v) A broker-dealer or agent whose performance of investment advisory services is solely incidental to the conduct of business as a broker-dealer and who receives no special compensation for the investment advisory services;

(vi) A publisher, employee, or columnist of a bona fide newspaper, magazine, or business or financial publication or service, whether communicated in printed form, by electronic means, or otherwise, with a regular paid circulation;

(vii) A publisher of a securities advisory newsletter, whether communicated in printed form, by electronic means, or otherwise, with a regular paid circulation who does not provide advice to subscribers on the basis of their specific investment situations;

(viii) An author of material included in a newspaper, magazine, publication, or newsletter who is not otherwise an investment adviser or investment adviser representative as defined under this section;

(ix) A person who provides investment advisory services solely while acting as an investment banker or business broker on behalf of one or more parties to, and in connection with, a transaction or proposed transaction for the transfer of a controlling interest in a business enterprise;

(x) An official, employee, or representative of the United States, a state, a political subdivision of a state, or an agency or a corporate or other instrumentality of the United States or a state, while acting in such person's official capacity on behalf of such entity;

(xi) A person excluded from the definition of "investment adviser" under § 31–5602.02(a)(11)(A) through (F) of the Investment Advisers Act of 1940;

(xii) A licensed real estate broker or salesperson whose advice to clients relates only to the investment in, or acquisition of, real property; and

(xiii) Any other person or class of persons not within the intent of this paragraph as the Commissioner, by rule or order, may designate.

(18) "Investment adviser representative" means:

(A) With respect to an investment adviser licensed or required to be licensed under this chapter, a partner, officer, director, or person occupying a similar status or performing similar functions, or other individual employed by or associated with an investment adviser, except clerical or administrative personnel, who performs any of the following functions:

(i) Makes any recommendations or otherwise renders advice regarding securities;

(ii) Manages accounts or portfolios of clients;

(iii) Determines which recommendation or advice regarding securities should be given;

(iv) Solicits, offers, or negotiates for the sale of, or sells, investment advisory services; or

(v) Supervises employees who perform any of the foregoing functions;

(B) With respect to a federal covered adviser, an individual employed by, or associated with, a federal covered adviser who is an "investment adviser representative" and who has a "place of business" in the District, as those terms are defined by rules promulgated by the Securities and Exchange Commission.

(19) "Investment Advisers Act of 1940" means the Investment Advisers Act of 1940, approved August 22, 1940 (54 Stat. 847; 15 U.S.C. § 80b–1 et seq.).

(20) "Investment Company Act of 1940" means the Investment Company Act of 1940, approved August 22, 1946 (54 Stat. 789;15 U.S.C. § 80a–1 et seq.).

(21)(A) "Issuer" means a person who issues, or proposes to issue, a security; provided, that with respect to certificates of deposit, voting-trust certificates, collateral-trust certificates, or certificates of interest or shares in an unincorporated investment trust not having a board of directors or persons performing similar functions or of the fixed, restricted management, or unit type, the term "issuer" means the person performing the acts and assuming the duties of depositor or manager under the provisions of the trust or other agreement or instrument under which the security is issued.

(B) Repealed.

(22) "Non-issuer transaction" means a transaction not directly or indirectly for the benefit of the issuer.

(23) "Person" means an individual, a corporation, a partnership, an association, a joint-stock company, a limited liability company, a trust where the interests of the beneficiaries are evidenced by a security, an unincorporated organization, a government, or a political subdivision of a government.

(24) "Price amendment" means the final federal amendment which includes a statement of: the offering price; underwriting and selling discounts or commissions; amount of proceeds; conversion rates; call prices; and other matters dependent upon the offering price.

(25) "Promoter" includes:

(A) A person who, acting alone or in concert with one or more other persons, takes the entrepreneurial initiative in founding or organizing the business or enterprise of an issuer;

(B) An officer or director owning securities of an issuer or a person who owns, beneficially or of record, 10% or more of a class of securities of the issuer if the officer, director, or person acquires any of those securities in a transaction within 3 years before the filing by the issuer of a registration statement under this chapter and the transaction does not possess the indicia of arms-length bargaining; and

(C) A member of the immediate family of a person identified in subparagraphs (A) or (B) of this paragraph if the family member receives securities of the issuer from that person in a transaction within 3 years before the filing by the issuer of a registration statement under this chapter and the transaction does not possess the indicia of arms-length bargaining.

(26) "Public Utility Holding Company Act of 1935" means the Public Utility Holding Company Act of 1935, approved August 26, 1935 (49 Stat. 838; 15 U.S.C. § 79a et seq.).

(27) "Sale" or "sell" includes every contract to sell, exchange, or dispose of a security or interest in a security for value. In this context:

(A) "Offer" or "offer to sell" includes every attempt or offer to dispose of, or solicitation of an offer to buy, a security or interest in a security for value;

(B) "Offer to purchase" includes every attempt or offer to obtain, or solicitation of an offer to sell, a security or interest in a security for value, but the term shall not include a transaction that is subject to section 14(d) of the Securities Exchange Act of 1934;

(C) A security given or delivered with, or as a bonus on account of, a purchase of securities or any other thing is considered to constitute part of the subject of the purchase and to have been offered and sold for value;

(D) A gift of assessable stock is deemed to involve an offer and sale;

(E) A sale or offer of a warrant or right to purchase or subscribe to another security of the same or another issuer, or a sale or offer of a security which gives the holder a present or future right or privilege to convert into another security of the same or another issuer, shall be considered to include an offer of the other security; and

(F) The terms "offer", "offer to sell", "sale", and "sell" shall not include:

(i) The creation of a security interest or a loan;

(ii) A stock dividend, whether the corporation distributing the dividend is the issuer of the stock or not, if nothing of value is given by stockholders for the dividend other than the surrender of a right to a cash or property dividend when each stockholder may elect to take the dividend in cash or property or in stock;

(iii) An act incident to a vote by security holders, pursuant to the certificate of incorporation or the applicable corporation statute or other controlling statute, a partnership agreement, or the controlling agreement among security holders, on a merger; triangular merger; exchange of securities for securities; consolidation; reclassi-

fication of securities; reorganization; or sale of corporate assets in consideration of the issuance of securities of another person other than an individual;

(iv) An act incident to a judicially approved reorganization in which a security is issued in exchange for one or more bona fide outstanding securities, claims, or property interests, or partly in such exchange and partly for cash; or

(v) An act as to which the Commissioner finds, by rule or order, that application of this paragraph is not necessary or appropriate for the protection of investors, and the finding is consistent with the public interest and the purposes fairly intended by the policy and provisions of this chapter.

(28) "Securities Act of 1933" means the Securities Act of 1933, approved May 27, 1933 (48 Stat. 74; 15 U.S.C. § 77a et seq.).

(29) "Securities Exchange Act of 1934" means the Securities Exchange Act of 1934, approved June 6, 1934 (48 Stat. 881; 15 U.S.C. § 78a et seq.).

(30) "Securities and Exchange Commission" means the United States Securities and Exchange Commission.

(31) "Security" means any note; stock; treasury stock; bond; debenture; evidence of indebtedness; certificate of interest or participation in a profit-sharing agreement; a limited partnership interest; collateral-trust certificate; preorganization certificate or subscription; transferable share; investment contract; voting-trust certificate; certificate of deposit for a security; fractional undivided interest in an oil, gas, or other mineral lease or in payments out of production under a lease, right, or royalty; a put, call, straddle, or option entered into a national securities exchange relating to foreign currency; a put, call, straddle, or option on a security, certificate of deposit, or group or index of securities, including an interest in or based on the value of any of the foregoing; or an interest or instrument commonly known as a security; or certificate of interest or participation in, temporary or interim certificate for, receipt for, whole or partial guarantee of, or warrant or right to subscribe to or purchase, any of the foregoing. The term "security" shall not include:

(A) An insurance or endowment policy or annuity contract under which an insurance company promises to pay a fixed sum of money in a lump sum, periodically for life, or for some other specified period; or

(B) An interest in a contributory or non-contributory pension or welfare plan subject to the Employee Retirement Income Security Act of 1974, approved September 2, 1974 (88 Stat. 832; 29 U.S.C. § 1001 et seq.).

(32) "Self-regulatory organization" means a national securities exchange registered under section 6 of the Securities Exchange Act of 1934; a national securities association of brokers and dealers registered under section 15A of the Securities Exchange Act of 1934; the Municipal Securities Rulemaking Board established under section 15B(b)(1) of the Securities Exchange Act of 1934; a clearing agency registered under section 17A of the Securities Exchange Act of 1934; or a futures association under section 21 of the Commodity Exchange Act.

(33) "State" means a state, territory, or possession of the United States, and Puerto Rico.

(34) "Underwriter" means a person who has purchased from an issuer with a view to, or sells for an issuer in connection with, the distribution of a security; participates, or has a direct or indirect participation in, such undertaking; or participates, or has a participation in, the direct or indirect underwriting of such undertaking. The term "underwriter" shall not include a person whose interest is limited to a commission from an underwriter or dealer not in excess of the usual and customary distributor's or seller's commission. As used in this paragraph, the term "issuer" shall include a person directly or indirectly controlling, or controlled by, the issuer or a person under direct or indirect common control with the issuer.

(Oct. 26, 2000, D.C. Law 13–203, § 101, 47 DCR 7837; June 25, 2002, D.C. Law 14–150, § 2(a), 49 DCR 4238; Oct. 19, 2002, D.C. Law 14–213, § 22, 49 DCR 8140; June 11, 2004, D.C. Law 15–166, § 4(hh), 51 DCR 2817.)

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